



LEICHHARDT SPORTS PHYSIOTHERAPY

PATIENT INFORMATION SHEET

Surname: _____ Given Names: _____

Address: _____

Suburb: _____ Post Code: _____

Telephone (w) _____ (h) _____ (m) _____

Occupation: _____ Date of Birth: _____

Email: _____ Health Fund: Yes/No _____

Leichhardt Sports Physio will under no circumstances sell, trade or rent any personal information that you supply to us to any third party.

What area of the body are we treating today _____

GP details

Referral Yes/No

Doctors Name:

Address:

Do you approve correspondence to your GP regarding your treatment Yes/No

How did you hear about this clinic? (please tick)

Doctor Referral	<input type="checkbox"/>	Shopping at MarketPlace	<input type="checkbox"/>	Trinity Grammar	<input type="checkbox"/>
Specialist Doctors Referral	<input type="checkbox"/>	Aust Physio Assoc Website	<input type="checkbox"/>	NRMA	<input type="checkbox"/>
Family/Friend	<input type="checkbox"/>	Need a physio Website	<input type="checkbox"/>	Sporting Club	<input type="checkbox"/>
Front Signage	<input type="checkbox"/>	Internet Search	<input type="checkbox"/>	Other (Specify)	<input type="checkbox"/>
Leichhardt Aquatic Pool	<input type="checkbox"/>	Annette Kellerman Pool	<input type="checkbox"/>		<input type="checkbox"/>

Please note below if applicable

Is this a Workers Comp Claim Yes/No Pls supply Dr's referral & W/Cover Certificate	<input type="checkbox"/>		Are you covered by Veterans Affairs Yes/No	<input type="checkbox"/>
Third Party Claim Yes/No Pls supply Dr's referral & W/cover Certificate	<input type="checkbox"/>		GP referred EPC – Enhance Primary Care Plan	Yes/No <input type="checkbox"/>
Further paperwork will be required for all Workers Comp/ Third Party/DVA Claims and EPC Care Plans.				

Would you like any information on the other services we provide at our clinic? (please tick)

Pilates	<input type="checkbox"/>	Massage Therapy	<input type="checkbox"/>	Hydrotherapy	<input type="checkbox"/>	Exercise programmes	<input type="checkbox"/>
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Terms and Conditions:

Payment is required at time of Consultation.

I understand that I will be personally responsible for all fees on my account.

A cancellation fee of \$40.00 applies if I do not give 24hrs notice of cancellation.

Full consultation fee may be charged if appointments are missed without notice.

If you are running more than 15minutes late you may have to re-schedule the appointment – please call the clinic.

An administration fee of \$5.50 will be charged for outstanding accounts of 30+days.

I ACCEPT THE ABOVE TERMS AND AGREE TO ABIDE BY THEM:

Patient's/Guardian's Signature:

DATE:



LEICHHARDT SPORTS PHYSIOTHERAPY

THE ULTIMATE RESPONSIBILITY FOR COMPENSABLE ACCOUNTS LIES WITH THE PATIENT

Signed: _____ Date: _____

WORKERS COMPENSATION ONLY – FILL IN ALL APPLICABLE INFORMATION

Employer: _____ Insurer: _____

Employer Phone No. : _____ Date of Accident: _____

Case Manager: _____ Claim No: _____

Direct Telephone No. : _____ Solicitor: _____

I, _____ hereby authorise any professional staff member of Lewisham Physiotherapy and Sports Medicine to divulge my employer and/or employers insurer, information in relation to my workers compensation claim which he/she may have acquired with regard to myself.

Signed: _____ Date: _____

MOTOR VEHICLE CLAIMS – FILL IN APPLICABLE INFORMATION

Insurer: _____ Claim No.: _____

Date of Accident: _____ Claim Manager: _____

Solicitor: _____ Telephone: _____

Solicitors Address: _____

Please read the following and indicate you understand these warnings with your signature

Heat Treatment:

When receiving heat treatment all you should feel is mild, comfortable warmth. If you feel any more than this, or if the heat concentrates in any particular spot, you must call your physiotherapist immediately, otherwise you may be in danger of being burned.

Electrical Stimulation:

When receiving electrical stimulation any concentration of the current of discomfort or pain must be reported immediately to your physiotherapist otherwise you may be in danger of sustaining an abnormal skin reaction. This may result in skin and tissue damage.

Signed: _____ Date: _____