# In Touch Hand Therapy

## Client Consent and Information Form

| PERSONAL INFORMATION | | | |
|---|---|---|---|
| **TITLE:** | | **PHONE:** | |
| **FULL NAME:** First and Middle Names | | **WORK PHONE:** | |
| **LAST NAME:** | | **MOBILE:** | |
| **PREFERRED NAME:** What you like to be known as. | | **EMAIL:** | |
| **GENDER:** | ☐ Male ☐ Female | **HOME ADDRESS:** | |
| **DATE OF BIRTH:** | | | |
| **NAME OF GP:** | | **POST CODE:** | |
| **MEDICAL PRACTICE:** | | **OCCUPATION:** | |
| **WHO REFERRED YOU?** | | **EMPLOYER:** | |
| **Ethnicity:** | Please select | **OTHERS:** | |
| **Are there any cultural considerations that should be addressed?** | | | |
| **HOW DID YOU HEAR ABOUT OUR CLINIC?** | Please select | **OTHERS:** | |

**Are you happy for us to text an appointment reminder to you:** ☐ YES ☐ NO

**Are you happy for us to use your email address for info about services and injury related topics:** ☐ YES ☐ NO

**SECTION 2 - GENERAL HEALTH QUESTIONNAIRE**

| | | | |
|---|---|---|---|
| ☐ Pregnant<br>☐ Physical disability<br>☐ Diabetes | ☐ Heart problems<br>☐ Skin condition<br>☐ Cancer<br>☐ Pacemaker | ☐ Hearing/sight impaired<br>☐ Hep C/HIV<br>☐ Other (Specify) ……<br>☐ Circulation/Vascular Problem | ☐ Asthma/Respiratory/ Breathing<br>☐ Artificial Implants<br>☐ Allergy (please specify) …… |

HAVE YOU USED OR ARE USING STEROIDS ☐ ANTICOAGULANTS ☐ OTHER MEDICATIONS?

**SECTION 3 – CONSENTS**

I hereby agree to consent to treatment by an appropriately qualified Physiotherapist for the purpose for providing comprehensive physiotherapy services as may be necessary in support of my illness, injury or condition. I have been given the opportunity to read clinic information prior to treatment. I understand I have the right to decline part or all of the treatment being offered. I understand my right to a second opinion.

**SECTION 4- TELEHEALTH OPTION**

| | | |
|---|---|---|
| I hereby agree to consent to treatment via Telehealth option. | **INITIALED:** | **DATED:** |

**SECTION 5 TELEHEALTH - ACC DECLARATIONS**

Do you declare that you have provided true and correct information and you will tell ACC if your situation changes? ☐ YES ☐ NO

Do you authorise me as your (name of health profession: GP, physiotherapist, etc) to lodge your claim with ACC? ☐ YES ☐ NO

Do you authorise your information to be collected or disclosed to ACC to help determine cover for your claim, determine what you will be entitled to, or for research purposes (like injury prevention, or assessment, and rehabilitation?). ☐ YES ☐ NO

**AGREEMENT TO PAY:**

I understand that I am liable to pay for:

- Any private treatment or copayment charges for ACC treatments.
- If I fail to attend my appointment without giving any notice, I am liable for the full cost of the appointment. If I cancel on the same day, I will be charged an admin fee of 50% of overall treatment costs, this includes the portion normally paid by ACC.
- If I fail to pay for my appointment at the time of treatment, I may be charged an account administration fee. I will also incur interest charged to my account at the rate of 2% above the current bank overdraft interest rate.
- Any treatment that is declined by ACC or any other funder.
- Any treatment covered by an insurer, must have the insurers consent supplied in writing prior to treatment.
- The costs of materials such as orthotics, materials, products etc. that are not covered by ACC or an insurer.

I understand that if this service requires to engage a Debt Recovery Service to recover my debt, I will be liable for all recovery fees and legal costs.

| **CONSENT TO RELEASE INFORMATION TO A 3rd PARTY** | |
|---|---|
| I consent to the disclosure of my records to any person/organisation necessary for the effective management of my condition.<br>I consent to a discharge/update report being sent to my doctor or medical centre.<br>I consent to **non-identifying** use of photos or medical data for training purposes | |
| I have read and understand the information above. **TYPE IN YOUR FULL NAME BELOW**<br>**SIGNED:** **DATED:**<br>(if *under 16 must be signed by parent/guardian)* | *Therapist Initials* |

**Please complete and save this this form on your device and email it back to us before your initial appointment: info@intouchhandtherapy.co.nz**