Client Details Form

Ipswich therapy centre
Helping you live, rest & play

Title (please circle)	Miss Mrs Mr Master Ms			Date of Birth		
First Name			Surname			
Address						
Phone	Home			Mobile		
Next of Kin	Name		Contact Number			
Email						
Cultural Identity (please circle)	Aboriginal Torres Strait Islander Non Indigenous Other……					
Medicare Card #			Ref #		Expiry	
DVA Card #			Type (please circle)		Gold White	
Private Health Fund Name			Membership #			
EPC Plan in Place? (please circle)	Yes No		# of Visits		Plan End Date	
NDIS Funded (please circle)	Yes No		NDIS #			
NDIS Plan (please circle)	NDIS Managed Self Managed Plan Manager					
Plan Mangement Details if applicable						
General Practitioner Name				Contact #		

Term and Conditions

Do you wish to be contacted for appointment reminders/recalls? (please circle) Yes No

What is your preferred method of contact? (please circle) Email SMS Phone Letter

If you are unable to keep your appointment, please notify us immediately. Cancellation fees may apply.

We ask for full payment of your account on the day of your consultation, you are then able to claim and Medicare/Healthfund rebate via our online system. EFTPOS facilities are available.

The personal information collected is that deemed necessary to best attend to, and treat the presenting health condition(s). Personal information is primarily used internally within the practice, but sometimes it is used to ensure quality and continuity of health care for you and must be partially or fully disclosed to others outside the organisation, depending on the circumstances. eg: when referring to a specialist medical practitioner, therapist or service providor or when itemising accounts for Medicare.

Amendments to the Privacy Act came into effect in December 2001. As a provider of healthcare services it is important that you are aware of how any personal information collected by this practice is used.

Freedom of Information: All patient files that include personal information, test results etc. are the property of this practice. However, should you choose to visit another therapisr at any time, copies of the appropriate file(s) can be forwarded on receipt of your written request. Under no circumstance will this practice provide or divulge personal information without your prior written consent.

I have read and understand all information provided above regarding fees, privacy and freedom of information. I am aware that at the conclusion of all consultations there will be a request for full payment of the account unless otherwise directed by the therapist.

Signed Patient/Guardian		Date	