ESC AUSTRALIA: EXERCISE PHYSIOLOGY

Specialists in exercise prescription for health and wellbeing. Rehabilitation interventions for chronic to athletic populations.

Jessica Brennan (Director / Principal Accredited Exercise Physiologist)

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ESSAM #: 16873 | SIRA #: 20342 | Medicare Provider #: 599897CF *(Wollongbar)*

Mobile: 0421 661 901 **| Email:** info@escaustralia.com **| Website:** https://escaustralia.com

Client Registration and Consent Form

You consent for an Accredited Allied Health Practitioner to gain medical and physical information pertaining to your presenting condition. This information will be treated with respect and adherence of confidentiality standards. You consent that you are engaging with Allied Health Practitioners that utilise evidence-based best practice to support clinical relevance for exercise prescription and exercise treatment plans, with the view to improve functional capacity. **|** You consent to complete the consultation, with the intention to engage in an individual client-focus exercise prescription treatment plan for the referred / planned number of sessions. You provide permission to perform exercise testing and prescription and this consent if given freely and voluntarily. You consent your rights are considered and you are free to cease at any point and for any reason.

Client details:			
Name:			D.O.B
Mobile:		Other Phone:	
Address:			
Email Address:			
Next of Kin:	Name:		Relationship:
Mobile:		Other Phone:	

Referral Type: *circle & write number*				
Private	DVA #	White Gold	Medicare #	Home / Lifetime Care Package
NDIS #	Work Cover #		3rd Party Provider	Other: *TCA, EPC, Contact*
Client recent medical history attached: YES / NO				
Current medication list attached: YES / NO			Consent to obtain from GP? YES / NO	

Your Personal Information and your health Record may be collected, used and / or disclosed for the following reasons:

- For communicating relevant information with other treating practitioner such as exercise physiologists, physiotherapists, general practitioner, specialists or other allied health professionals
- For follow-up reminders or recall notices
- For national / state or territory registers or reminders systems; For Accounting / Medicare / Health Insurance procedures
- For quality assurance activities such as accreditation
- For use by all practitioners in this group practice when consulting with you
- For legal disclosure as required by a court of law (e.g. subpoena, court order, suspected abuse)
- For research purposes (de-identified, meaning you are not able to be identified from the information given)

If you have any concerns for wish to restrict access to your personal health information, please discuss these with your practitioner or the administration team. This practice adheres to National Privacy Principles (www.privacy.gov.au).

You consent communication with your Physicians? YES / NO | You consent obtaining diagnostic reports? YES / NO

PLEASE NOTE: This practice requires payment at the time of treatment. If an insurer, (third party provider, personal insurer or workers compensation) denies your claim, you become responsible for outstanding accounts. Please tick, if you understand ☐

Patient / Guardian Signature _____ **Date:** _____

General Practitioner (GP) / Specialist / Surgeon details:			
Dr Name: Dr Provider Number:		Dr Name: Dr Provider Number:	
Clinic:		Clinic:	
Ph:	Fax:	Ph:	Fax:
Email:		Email:	