Proactive

School Client Consent Information Form

SECTION 1 - PERSONAL INFORMATION

TITLE:	**PHONE:**
CLIENT NAME ..	**MOBILE:**
PARENT EMAIL:	**ETHNICITY:**
DATE OF BIRTH: «ClientDob	**OCCUPATION:**
HOME ADDRESS **STREET:**	**PARENT** **DETAILS** **Form Class**
GP **NAME:**	**GP PRACTICE:**

WHY DID YOU CHOOSE US : ☐ Recommended Clinic	☐ Recommended Who: ……	☐ Previous treated ☐ Doctors Referral	☐Location ☐ Other:……..
WHO REFERRED YOU? ☐ GP	☐ Specialist ☐ Physiotherapist	☐ Friend/Family	☐Other ……

SECTION 2 - GENERAL HEALTH QUESTIONNAIRE:

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

ACC 45 SECTION 3 - ACC DETAILS

DATE OF INJURY:	**How did injury happen?** (Describe)
PLACE OF INJURY: (E.G. Home, Work, School etc)	
TIME OF INJURY:	**Location**: (e.g Christchurch, Auckland)
Is this an ACC Injury ☐ YES ☐ No	**ACC Claim No (if Known)** DO NOT FILL ANY FURTHER DETAILS IF CLAIM REGISTERED
Work Related Injury: ☐ YES ☐ No	

Work Intensity: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

ACC DECLARATION:

I DECLARE – The information I have given about this claim is true and correct and that I have not withheld any information.
I AUTHORISE – The treatment provider to lodge the claim for me. The collection and release of any information about me to the extent that this is needed to prevent future injuries, determine cover and/or assess my entitlement to compensation, rehabilitation assistance, medical treatment and/or the appropriate level of care and personal attention I should receive. ACC to contact anyone who holds relevant information, including any external agencies or service providers (such as medical practitioners, specialists, New Zealand Police and Treatment Providers, IRD, WINZ, Assessment Agencies, employers and witnesses to the accident.

SECTION 4 – CONSENTS

I hereby agree to consent to treatment by an appropriately qualified Treatment Provider. This will include an initial interview (assessing injury history and areas of need), examination and a full verbal explanation of planned treatment. I understand that at any time I am able to consider other options, access a second opinion, withdraw consent or refuse treatment without any prejudice against myself or the person on whose behalf I am acting. I am also aware that at any stage I have the right to advocate or have a support person present at assessment or treatment.
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.

AGREEMENT TO PAY:

I understand that I am liable to pay for :

- Any private treatment or copayment charges for ACC treatments and other Insurers
- If I fail to attend my appointment or cancel without reasonable notice I may be charged a fee of $20.
- If I fail to pay for my treatment/product/service at the time of my appointment then I may incur a $5.00 Account Management Fee.
- Any treatment that is declined by ACC or other funder.
- The costs of materials such as tape, products etc

I understand that if this service requires to engage a Debt Recovery Service and/or Solicitor to recover my debt, I will be liable for any recovery fees.

CONSENT TO RELEASE INFORMATION TO A 3rd PARTY

You consent for Proactive to liaise with your regular General Practitioner or Specialist if required. In accordance with the Privacy Act all information recorded in your health records will be kept confidential. Your record will only be accessed for the purpose for providing comprehensive physiotherapy services as may be necessary in support of your illness, injury or condition.

SIGNED: **DATED:**

(If under 16 must be signed by parent/guardian) I have read and understand the information provided in this document. I fully agree to all the Terms/Conditions and Consents as set out above and have signed freely without prejudice

TREATMENT PROVIDER SIGNED: **DATED:**