women's & men's health PHYSIOTHERAPY

549 Burke Rd, Camberwell 3124
T: 03 8823 8300 | F: 03 8823 8399
E: physio@wmhp.com.au

170 Thomas St, Hampton 3188
T: 03 9521 0444 | F: 03 9521 0777
E: hampton@wmhp.com.au

ABN: 31 108 318 396
www.wmhp.com.au

ADMIN
SURNAME……
CLIENT # ……
PHYSIO'S INITIALS……
CONSULT DATE……

PRIVACY CONSENT & FEE INFORMATION

Our practice has a Privacy Policy on the collection, use, disclosure and security of information obtained from our patients. A copy of the policy is on our website and our full Privacy Policy is available upon request.

We are committed to providing you with high quality, continuing care, including protection of the confidentiality of your records. As part of this care and in compliance with the Privacy Legislation, we require you to sign this privacy form. It is important that we gain your consent to collect and use personal information:

- For use by all physiotherapists in this group practice when consulting with you
- For collating information within this practice to ascertain treatment effectiveness
- For legal related disclosures as required by a court of law
- For research purposes (de-identified, you are not able to be identified from information given)
- For Accreditation and Quality Assurance activities conducted by professionally trained non-treating physiotherapists

In the process of ensuring quality treatment provision, information regarding your condition and treatment may be given and received by doctors and other treatment providers.

I am aware that I can access my personal treatment information on request. I have read the above information and understand the reasons for collecting information and the ways in which this information might be used.

☐ I give permission for *Women's and Men's Health Physiotherapy* to collect data relating to my treatment, providing my privacy is ensured

☐ I do not give permission for *Women's and Men's Health Physiotherapy* to collect data relating to my treatment

Parent/Guardian (Patient's Under 18's Years of Age)

I,*.....(Parent/Guardian),* have read, understood and agreed to the above information on behalf of myself and my child (the patient). I consent to the reasons for collecting information and understand the reasons for this and the ways in which this information might be used.

Signed..... Date...../..../20.....
(Parent/Guardian)

FEE INFORMATION

Payment is required on the day of consultation (or upon receipt of your account if attending one of our offsite locations).Please provide 24 hours' notice for cancellation or alteration of your appointment. This will enable us to offer the consulation time to patients on our waiting list. A non-attendance or late cancellation will attract a fee. In the event of the account being in default, patient information (contact and account details only) will be referred to an external party for collection. The patient shall be liable for all costs incurred arising from the recovery; including commission which would be payable if the account is paid in full and legal costs including demand costs.

Signature: _____ Date: _____

Print: _____