THE PHYSIO ROOM - SACRED HEART GIRLS COLLEGE

Dear Parent/Caregivers,

Active Health provides physiotherapy at SHGC on Tuesdays and Fridays, 9am-noon.

Fees Payable are:	ACC	
Initial Assessment	$20	
Follow up Consultation	$20	Additional charges may apply for materials eg. tape

Payment is due at the time of treatment (Cash or Bank Deposit) unless otherwise arranged. A $10 account fee may apply
Account details are: BNZ; Active Health Waikato LTD; Account Number 02-1268-0011127-00

SECTION 1 – PERSONAL INFORMATION – PATIENT * Compulsory Fields

Title:*	Address:*
First Names:*	Postcode:
Preferred Name:	
Last Name:*	Mobile:*
Date of Birth:*	Email: *
Ethnicity: * (Eg NZ European, Māori Etc)	Occupation:
GP/Medical Practice:	

SECTION 2 – GENERAL HEALTH QUESTIONNAIRE

☐ Physical Disability ☐ Heart Problem ☐ Hearing/sight impaired ☐ Asthma/Respiratory/Breathing
☐ Pregnant ☐ Skin Condition ☐ Hep C / HIV ☐ Artificial Implants
☐ Diabetes ☐ Cancer ☐ Pacemaker ☐ Allergy (Please Specify) _____
☐ Circulation/Vascular Problem ☐ Other (Please specify) _____

SECTION 3 – ACC – "How did the injury happen?"

Is this an ACC Injury ☐ Yes ☐ No	ACC 45 or Claim #:	Date of Injury:
Have you had physio on this claim? ☐ Yes (Please specify how many) ☐ No	Time of Injury:	PLACE OF INJURY: (eg Home, Work, School, Road etc)
Location: (eg Hamilton)	How did the injury happen? (Describe what you were doing and what part of the body is injured)	

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/or witnesses to the accident).

PARENT/CAREGIVER: Please give your consent by signing below. This form must be given to the Physio AT THE FIRST appointment. If this is not signed, treatment cannot go ahead. The Physio will advise the student of the number of expected treatments after the first consultation.

I GIVE CONSENT for (student) _____ to have treatment and I agree to the above co-payment for each treatment.

Parent Name_____ Date: _____

Parent Email: _____ Parent Ph: _____

Email: thomasrd@activehealth.co.nz Clinic Ph: 07 8537096 Web: www.activehealth.co.nz

Now Book Here
Take a pic, you'll go to the online booking site!