HANDWORKS REGISTRATION AND CONSENT

NAME: *		DOB: *
ADDRESS:	PH(h) *	(w)
	Mob: * text to remind offered	
GP:	MEDICAL INSURER:	
OCCUPATION:	EMPLOYER: *	

INJURY CASE MANAGEMENT	YES	NO	CLAIM NUMBERS
Have you completed an ACC 45 claim form for this injury?			(top right ACC45)
Have you received an acceptance letter from ACC			(in acceptance letter)
Date of injury: (must be completed *)	Injury description: R L		
Read Codes: (therapist to complete)			
Who did you first see with this injury? and who completed the medical side ® of ACC45 ?			

Did your injury occur at work? *	Y	N	Detail.
Does your employer use a separate Insurer for work injuries ?			
Are you currently off work / have a Case Manager.?			
Have you had any other therapy / treatment for this injury ? when ?			

MEDICAL HISTORY:

Information required for your safety and protection	YES	NO	DETAIL
Are you being treated for any medical condition that may affect our treatment. ((ie asthma, arthritis ,angina, allergies, diabetes, carcinoma, skin conditions)			
Are you taking any long term medication?			
Have you had any recent infections?			
Do you wear a hearing aid or a pacemaker.			
If female ; could you be pregnant?			
Have you had any previous surgery to this limb?			

CLIENT CONSENT : (to be completed before treatment commences)

In accordance with the Privacy Act all information recorded on your records will be kept confidential. Your record will only be accessed by the person providing your care and by those staff responsible for maintaining files. You have the right of access to, and correction of, your personal information held by this practice.
No information will be given to a third party without your consent; however under ACC regulations you have already agreed to the collection and disclosure of information to ACC about your case, to the extent necessary to determine/assess entitlement for treatment.

- I hereby give consent to undertake treatment with Handworks bearing in mind a full verbal explanation will be given at the time of treatment , affording me the right to decline all or part of the treatment offered to me at that time.
  Under ACC terms you also accept that you have to take personal responsibility for your rehabilitation and to actively participate in the treatment plan developed.
- I undertake to pay the costs of treatment and / or materials where these are <u>not covered by ACC or an Insurer</u> ; and retrospectively, if any ACC or Insurance claim is declined once treatment has commenced.

Non attendance (failure to advise 4 hours prior) will be charged at a rate currently posted in practice.
All mailed accounts will incur an account fee.
Any outstanding debts may be transferred to a third party: in the event of which you would be liable for the added recovery costs.

CLIENTS SIGNATURE:	Date:
CHECKED BY THERAPIST: initial	ENTERED BY OFFICE: initial