

HANDWORKS REGISTRATION AND CONSENT

Welcome to our clinic and thank you for taking the time to complete the following to help us treat you safely and effectively.

Section 1: REGISTRATION and CLAIM DETAILS

Name:	Date of Birth:	NHI No:
Address:	Phone (Home) :	
	Phone (Business/Work):	
	Mob: <small>(text to remind service offered)</small>	
Email:	Medical Insurer:	
GP:	Employer:	
Occupation:		
Reason for attending Handworks:		
Who referred you:		

If non ACC please move to Section 2 over page

<u>INJURY CASE MANAGEMENT</u>	YES	NO	ACC45 or CLAIM NUMBER	
Have you completed an ACC45 claim form for this injury?				
Whom did you first see with this injury? And /or who completed the medical side of ACC45?				
Have you received an acceptance letter from ACC?				
Date of injury:	Description of Injury:		Left	Right
Have you already had any HAND THERAPY elsewhere for this injury? YES / NO	Where:		When:	No of visits:
Have you had any SURGERY for this injury? YES / NO	Surgeon/Clinic		When:	ACC approved? YES / NO
Did your injury occur at work? YES / NO	Does your employer use a separate Insurer for work injuries?			

Section 2: General Health and Consent

GENERAL HEALTH QUESTIONNAIRE: Thank you for completing this information for us to treat you safely .	YES	NO	DETAILS
Are you being treated for any medical condition that may affect or be affected by our treatment of you? (e.g. hepatitis C, HIV, asthma, arthritis, angina, allergies, cancer, diabetes, infection, skin condition, other)			
Are you taking any significant or long term medications ?			
Do you wear a hearing aid or have a pacemaker ?			
If female; could you be pregnant ?			
Do you have any metal implants ?			
Have you had any previous surgery to this limb?			
Do you have any new or worsening respiratory symptoms – cough, sore throat, shortness of breath, runny nose or loss of sense of smell, with or without a fever?			
Have you been in contact in the last 2 weeks with others who have been unwell with respiratory symptoms or fever, or are suspected or confirmed cases of COVID-19 ?			
Are you a high risk of severe illness from COVID-19 ?			
Any other health information you feel we should know about?			

CLIENT CONSENT: Please read carefully then sign and date. If you have any queries please ask a staff member.

In accordance with the Privacy Act all information recorded on your records will be kept confidential. Your records will only be accessed by the person providing your care and by those staff responsible for maintaining records. 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. This may include telehealth consultation if face to face access is unavailable.*** Under ACC regulations 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 any treatment and /or materials (this includes telehealth) where these are not covered by ACC or my employer. This includes retrospective fees, if any ACC or Insurance claim is declined once treatment has commenced.***
- Any outstanding debts may be transferred to a third party: in the event of which you would be liable for the added recovery costs. All mailed accounts will incur an account fee.**
- NB. Non attendance / failure to advise 24 hours prior, will be charged at a rate currently posted in practice.**

Signature (Client / Caregiver):	Printed Name:	Date: