NEW Client Consent and ACC Information Form

ACC45 #: _____ New / Existing
Injury: _____
Entered ☐ E-Sent ☐ **College**:

SECTION 1 - PERSONAL INFORMATION (Please complete all sections)

FIRST NAME:	**PREFERRED NAME:** (if different)	
LAST NAME:		☐ **MALE** ☐**FEMALE**
DATE OF BIRTH:	**ETHNICITY:**	**CELLPHONE:**
HOME PHONE:	**WORK PHONE:**	**Emergency Contact Number and Name:**
E-MAIL ADDRESS: Email addresses will only be used by us for sending of exercise programs, newsletters and surveys.		**Parent/Caregiver:**
ADDRESS:		
SUBURB:		
POSTAL ADDRESS:		**POST CODE:**
OCCUPATION:	**EMPLOYER NAME POSTAL ADDRESS: *(*IF WORK PLACE INJURY)***	
WORK INTENSITY: Light/Moderate/Heavy		
NAME OF GP:	**MEDICAL PRACTICE:**	

HOW DID YOU HEAR ABOUT US:
☐ Previous Patient ☐ GP ☐ Specialist ☐ Yellow pages ☐ White pages ☐ Local directory ☐ FIT CLUB
☐ Signage ☐ Flier ☐ Local paper ☐ Sports team ☐ College ☐ Other (please specify)

WHAT MADE YOU CHOOSE US:
☐ Previous Patient ☐ Word of Mouth/Family/Friend ☐ Location ☐ Able to get appointment ☐ First one I called
☐ Price ☐ GP/ Specialist Referred ☐ Services offered ☐ College ☐ Other (please specify)

SECTION 2 - GENERAL HEALTH QUESTIONNAIRE:

☐ Pregnant	☐Osteoporosis	☐ Asthma/Respiratory/Hyperventilation	☐ Circulation
☐ HIV/Hep C	☐ Cancer	☐ Continence Issues	☐ Hearing/sight impaired
☐ OsteoArthritis	☐ Allergy (Specify)	☐ Stress/Anxiety	☐ Physical disability
☐ History of Falls		☐ Heart/ Cardiovascular condition	☐ Intellectual Disability

MEDICATIONS – PLEASE LIST:

SECTION 3 - ACC CLAIM INFORMATION *(Do Not Complete if Private Patient)*

DATE OF INJURY:			**SCENE/SITE:** e.g. Home, ***Work**, Sport, School, Vehicle
TIME OF INJURY: (approx)			**LOCATION:** e.g. Tauranga, Auckland
Body Part	Circle **L R**	**Read Code:**	**DESCRIPTION OF HOW INJURY OCCURED:**

SECTION 4 - CONSENTS

I hereby agree to consent to treatment by an appropriately qualified Physiotherapist for the purpose for providing comprehensive physiotherapy services as may be necessary in support of my illness, injury or condition. 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 :

- **Treatment if it is not covered by ACC**
- **Any KCP co-payment charges for my treatment, which is not covered by ACC.**
- **Any treatment that is declined by ACC or other funder**
- **The costs of materials such as collars, splints, tape etc**
- **If I fail to attend or cancel my appointment within 4 hours I will be required to pay a non attendance fee (details at reception)**

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

CONSENT TO RELEASE INFORMATION TO A 3RD PARTY

I consent to the disclosure of my records to any person/organization necessary for the effective management of my condition.
I consent to a discharge/update report being sent to my doctor or medical centre.

ACC DECLARATION

I DECLARE: That the information I have given about this claim is true and correct and that I have not withheld any information likely to affect my application.
I AUTHORISE: 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 that 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 injury)

SIGNED: ***(If under 16 must be signed by parent/guardian & contact number)*** **DATED:**	**Office Use:** Notes completed if offsite	**Tick**	**No.**