Client Registration Form

Please Print Clearly

Mr / Mrs / Miss / Ms (Please circle)

SURNAME:_____

FIRST NAMES:_____

ADDRESS:_____

SUBURB: _____**POSTCODE**: _____

DATE OF BIRTH: _____/_____/_____ **OCCUPATION**: _____

PHONE: Work:_____ Home: _____

Mobile: _____ Email: _____

AREA/S TO BE ADDRESSED: _____

REFERRAL SOURCE: Please circle

Family Member / Friend / Sign / Doctor / Physio / Red Banner/
Yellow Pages/ Other _____

Referring Doctor / Physio: _____

Clinic Address: _____

STUDENT / PENSIONER: Yes / No

PRIVATE HEALTH COVER: Yes (Fund_____) / No

DECLARATION:
I hereby agree to pay all associated fees relating to my consultations performed at this clinic. **Cancellation fees apply should you cancel an appointment with a physiotherapist on the day of that appointment.** I acknowledge that if an account is overdue, Pilates Bayside reserves the right to refer the account to a collection agency. I agree to meet all reasonable costs and commissions incurred by this clinic in employing the said agency to collect the overdue account. I have read and understand this fee arrangement.

I acknowledge that I need adequate education, explanation and instructions regarding Pilates and the use of the Pilates Equipment, and will not commence on Group Exercise / Individual Practice Sessions without feeling that I have received this.

I fully understand any risks involved and take responsibility for my own actions. I will inform a physiotherapist if I feel unwell, develop pain and have symptoms which worsen or change.

Have you been informed about time restrictions for your independent sessions, when making your Initial Consultation? YES/NO
If No, please discuss with reception.

Client Signature : _____Date: ____/____/_____

Please Turn Over for WorkCover, Veteran's Affairs and TAC Claims

WORKCOVER

Was this injury reported to your employer? Yes / No
Have you completed the necessary claim forms? Yes / No
Is this a recurrence of a previous injury for which a WorkCover claim was submitted? Yes / No
Has your claim been accepted? Yes / No

Employer's Name: _____
Employer's Address: _____
Suburb: _____ Postcode: _____
Contact Person: _____
Claim Number: _____
Accident Date: _____/_____/_____

Insurance Company: _____
Contact Person:_____

I understand that irrespective of action taken on my behalf for fee collection, the account remains my responsibility.

Patient Signature: _____ Date: ___/___/___

VETERAN'S AFFAIRS

DVA Number: _____
Have you attended another physiotherapist in the past 6 months? Yes / No

TAC

Have you completed the necessary claim forms? Yes / No
Has the claim been accepted? Yes / No
Has the private payment threshold been reached? Yes / No
TAC No: _____
Contact Name: _____
Date of Accident: _____/_____/_____

I understand that irrespective of action taken on my behalf for fee collection, the account remains my responsibility.

Patient Signature:_____ Date:____/____/____