| Personal Details | | | |
|---|---|---|---|
| **Title:** | Please circle<br>Mr Mrs Miss Ms Dr Other: | | |
| **First Name:** | | | |
| **Surname:** | | | |
| **Date of Birth:** | | Name of Parent/Guardian (if under 18) | |

| Contact Details | | | |
|---|---|---|---|
| **Mobile number:** | | | Opt out for SMS reminder ☐ |
| **Home number:** | | **Work number:** | |
| **Email Address:** | | | Opt out for emails from tm physio only ☐ |
| **Street Address:** | | | |
| **Suburb:** | | | **Postcode:** |
| **Occupation:** | | | |
| **Employer:** | | | |
| **Emergency Contact:** | Name | | Contact Number |

| Referrer Details | | | | |
|---|---|---|---|---|
| **Referrer: (Please Tick)** | ☐ Website/Internet | ☐ Doctor | ☐ Yellow Pages | ☐ Belconnen Bowls ☐ |
| | Location | ☐ Dentist | ☐ Yellow Pages Online | ☐ Belsouth |
| | ☐ Friend | ☐ Podiatrist | ☐ Recommended | ☐ Kippax Tennis |
| | ☐ Family | ☐ Insurance | ☐ Returning Patient | ☐ Other_____ |

| **Referrer Details** (please give details if known) | Name | Address | Phone No. |
|---|---|---|---|
| | | | |

**If you are claiming through Workers Compensation or CTP please complete the WC/CTP form overleaf**

**Conditions of Treatment**

1. A fee will be charged if you fail to attend an appointment.
2. If less than 24hrs notice is given for a cancellation, a cancellation fee will be charged. Considerations will be given for unavoidable circumstances.
3. I do agree to information about my present or subsequent medical condition being communicated, verbally or in writing, with my referring doctor, other treatment medical practitioners and those involved in payment of fees associated with my treatment.
4. I understand that irrespective of action taken on my behalf for collection of this account, the account remains my responsibility.
5. In consideration of tm physio waiting for payment, I agree that you can charge a monthly administration fee for outstanding accounts.
6. I have read and fully understand tm physio Office Policy Form.

**Patient's Signature:**_____ [*parent / guardian if under 18 years of age*]

**Date**:_____

| Workers Compensation or CTP Details | | | |
|---|---|---|---|
| **Insurer:** | | | |
| **Date of Injury:** | | | |
| **Case Manager:** | | | |
| **Contact No.:** | | | |
| **Referring GP:** **(if applicable)** | Name | Contact No. | |
| | Address | | |
| **Claim No.:** | | | |
| **Insurers details:** | Address | Phone No. | |
| | | Fax No. | |
| | Email | | |