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| **CAMBRIDGE FAMILY OSTEOPATHS**166 SHAKESPEARE STREET, LEAMINGTON 3432 **Client Consent and Information Form** |
|  **SECTION 1 - PERSONAL INFORMATION** |
| FIRST NAME |  | DOB |  |
| SURNAME |  | EMAIL |  |
| ADDRESS |  | MOBILE NO |  |
|  |  | PHONE (W) |  |
| POSTCODE |  | GP |  | OCCUPATION |  |
| DATE |  | MALE/FEMALE |  | ETHNIC BACKGROUND |  |
| How did you hear about us? | Internet |  | Friend |  | Facebook |  | Advert |  | Other |  |
| **SECTION 2 – GENERAL HEALTH QUESTIONNAIRE** |
| Please tick below any conditions that apply & explain below |
|  | Asthma/Respiratory/Breathing |  | Heart attack/Chest Pain |  | Headache/Migraine |
|  | Allergies/Food intolerance |  | Cancer |  | Dizziness/Fainting |
|  | Diabetes |  | Depression |  | Arthritis |
|  | Epilepsy |  | Stroke |  | Osteoporosis |
|  | High/Low Blood Pressure |  | Pregnant |  | Musculoskeletal problems |
|  | **NONE OF THE ABOVE** |  |  |  |  |
| Explain: |
|  |
| List any injuries, accidents, operations: |
|  |
|  |
| Previous Treatment: |
| Tell us about the problem you would like us to treat (Presenting Condition): |
|  |
|  |
| **SECTION 3 - CONSENTS** |
| I hereby agree to consent to treatment by an appropriately qualified Osteopath for the purpose for providing comprehensive Osteopathy 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:* ACC Surcharge $50 per visit
* Private Treatments $70 per visit
* If I fail to attend my appointment or cancel without reasonable notice I may be charged a fee
* Any treatment that is declined by ACC or other funder

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/organisation necessary for the effective management of my condition. I consent to a discharge/update report being sent to my doctor or medical centre |
| I have read and understand the information above. **SIGNED: DATED:**(If under 16 years must be signed by parent/guardian)  | *OSTEOPATHS INITIALS* |
| Image result for drawing of a man's body**Front L****Front R** | Image result for drawing of a man's body**Back L****Back R** |