Please fill out the following details as clearly and fully as possible. To provide quality treatment we need to understand as much about your health as you do.

If you have any questions please ask for assistance. Thank you

Your Contact Details.

Name _____

Address _____

_____

Phone Hm _____ Wk _____ Mob _____

Email _____

Occupation _____ Date of Birth_____/_____/_____ Age_____

How did you find out about us?

☐ Word of mouth ☐ Doctor/GP ☐ Advertising ☐ Other

Details/their name? _____

What is your current Doctors/GPs name? _____

Payment: I undertake to pay any treatment charges that I may incur after treatment unless other arrangements are made.

Cancellation Fee: I acknowledge that a $60 fee may be payable if I cancel an appointment without a minimum 24 hours notice.

Consent: I consent to treatment and undertake to inform the practitioner if I am not in agreement with any procedure which has been recommended and explained to me. I consent to the release of information relating to any medical condition to other parties such as Medical Specialists, Treatment Providers, ACC, Insurance Companies and Employers.

Signed _____ Date _____/_____/_____

(Children under the age of 16 require a Parent/Legal Guardian to sign the form)