



## New Patient Registration Form

Title:  Mr  Mrs  Miss  Ms  Other

First Name \_\_\_\_\_ Surname \_\_\_\_\_

Street Address \_\_\_\_\_

Suburb \_\_\_\_\_ Postcode \_\_\_\_\_

Home telephone \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Email \_\_\_\_\_

**Emergency Contact Person** \_\_\_\_\_ **Mobile** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Do you Identify as Indigenous/TSI Yes/No

Referred by  Dr/Specialist Referral  Dentist  Family  Friend  Our website  Local Directory

Name \_\_\_\_\_

Your Dr/ Dentist/ Surgeon/Specialist Name \_\_\_\_\_

Dr/Dentist/Surgeon/Specialist Address \_\_\_\_\_

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### **Third Parties**

Do you have a DVA card?  Number \_\_\_\_\_ expiry \_\_\_\_\_

Do You Have Private Health Yes/No Name of Organisation \_\_\_\_\_

Member Card Number \_\_\_\_\_ Date joined fund: \_\_\_\_\_ Member number \_\_\_\_\_

Workers Compensation  Other Insurer (eg QBE)  \_\_\_\_\_ Claim Number \_\_\_\_\_

Your Case Manger's Name \_\_\_\_\_

Case Manager's Contact email \_\_\_\_\_ Phone number \_\_\_\_\_

Date of Injury \_\_\_\_\_

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Occupation \_\_\_\_\_

Hobbies/Sports \_\_\_\_\_

**COVID-19**

COVID-19 has presented us with an unprecedented challenge. Australians are being asked to take measures that we've never had to before – things like cancelling travel, not going to concerts and general social distancing.

You may be wondering how this affects your physiotherapy treatment.

We have recently upgraded our in office facilities to cater to being COVID-19 Safe.

WE ARE CURRENTLY OPERATING UNDER DIFFERENT LEVELS OF CAUTION REGARDING COVID

STAGE 1. Is when there is no community transmission in Qld.

STAGE 2. Is when there **is active community transmissions** in Qld and not on the Sunshine Coast.

STAGE 3. Is when there **is active community transmissions** on the Sunshine Coast.

STAGE 3 REQUIRES YOU TO WEAR A MASK BEFORE ENTERING THE PRACTICE OR PLEASE STAY AT HOME.

Have you/anyone in your household returned from overseas travel or hot spot area's in the last 10 to 14 days? Yes/No

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What is your main problem?

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What do you hope to achieve from therapy? What are your expectations?

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Level of Pain \_\_/10  Constant  Intermittent  Pins & needles  Numbness

How long have you had this problem? \_\_\_\_\_

Have you had this or a similar problem in the past? \_\_\_\_\_

Since the problem started, is it :  getting better  same  getting worse?

What makes your pain worse?  walking  sitting  standing  Other \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

How is your general health? \_\_\_\_\_

**Do you have or have ever had:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> High/Low Blood Pressure                   | <input type="checkbox"/> Bleeding disorder/ blood infections |   |
| <input type="checkbox"/> Stroke                                    | <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Panic attacks or needle phobia |
| <input type="checkbox"/> Heart Problems                            | <input type="checkbox"/> Epilepsy                            | <input type="checkbox"/> Current or recent infection    |
| <input type="checkbox"/> Pacemaker or valve replacement            | <input type="checkbox"/> Auto Immune Disease                 | <input type="checkbox"/> Mastectomy                     |
| <input type="checkbox"/> Bladder/Bowel difficulties                | <input type="checkbox"/> Cancer                              | <input type="checkbox"/> Aneurysm                       |
| <input type="checkbox"/> Osteoporosis                              | <input type="checkbox"/> Psoriatic Arthritis                 | <input type="checkbox"/> Osteoarthritis                 |
| <input type="checkbox"/> Rheumatoid Arthritis                      | <input type="checkbox"/> Joint Replacements                  | <input type="checkbox"/> Implants                       |
| <input type="checkbox"/> Spinal Trauma                             | <input type="checkbox"/> Spinal Surgery                      | <input type="checkbox"/> Spinal Fracture                |
| <input type="checkbox"/> Recent Nausea/feeling unwell              | <input type="checkbox"/> Dizziness                           | <input type="checkbox"/> Tinnitus                       |
| <input type="checkbox"/> Dislocations                              | <input type="checkbox"/> Ligament Injuries                   | <input type="checkbox"/> Cartilage injury               |
| <input type="checkbox"/> Ankylosing Spondylitis                    | <input type="checkbox"/> Unexplained weight loss             | <input type="checkbox"/> Bruising/bleeding              |
| <input type="checkbox"/> Steroid/Cortisone/Prednisone therapy      | <input type="checkbox"/> Pregnant or attempting              | <input type="checkbox"/> Allergies                      |
| <input type="checkbox"/> Lung condition / respiratory difficulties |  |   |

Further details

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Current Medications and /or Therapy \_\_\_\_\_

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Please indicate any special investigations you may have had or any relevant results. Can you please upload or email these results?

- X Rays    CT Scan    Ultrasound    MRI    Other

## TREATMENT CONSENT

**Heat Treatment:** When receiving heat treatment, all you should feel is a mild comfortable warmth. If you feel any more than this, you must notify the physiotherapist immediately as there is a possibility you may be burnt.

**Electrical Stimulation:** When receiving electrical stimulation, any concentration of the current discomfort or pain must be reported immediately to the physiotherapist. Otherwise there is a possibility of sustaining an abnormal skin reaction or tissue damage.

**Assessment:** You will be asked to expose the injured area of your body so the physiotherapist can assess and treat you. Should you feel uncomfortable about this, please advise our staff as there are alternative methods available. Please advise if you have any allergies to creams, tapes or needles.

### **Acupuncture and Dry Needling: *potential risks/side effects?***

- Minor bleeding or bruising may occur in approx. 3% of treatments
- Symptoms may temporarily worsen after treatment, please advise your physiotherapist if this should occur
- Fainting or dizziness may occur, particularly with the first treatment
- Rarely may cause temporary local swelling
- Bodily infection or collapse of the lung in extremely rare cases (less than 1 in 70,000-1,28 million)
- Drowsiness may occur after treatment. If affected, you are advised NOT TO DRIVE or OPERATE HEAVY MACHINERY until symptoms have resolved.

Your therapist will screen you for any reason why extra care is required or whether acupuncture /dry needling is an appropriate treatment for you.

**Questions of a personal nature :** Your physiotherapist may ask personal questions relating to your injury and how your injury impacts on your 'activities of daily living'. The more information you provide, the more likely it is that the physiotherapist can provide an effective treatment. It is your choice as to what information you choose to provide. If you feel uncomfortable with a particular question or group of questions, please let the physiotherapist know and they will cease.

**Physical Contact :** During the examination, assessment and treatment it may be necessary for your physiotherapist to make physical contact. Your physiotherapist will ask your permission before making physical contact with you in any way. Wherever possible, contact will be made using a towel or other forms of screening. Physical contact requires your express consent. You may withdraw consent at any time at which point, all physical contact will cease immediately. Please inform your physiotherapist if you feel uncomfortable at any time.

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### **\*ONLY IF APPLICABLE\* Women's Health**

The initial Women's Health consultation with Lynette involves assessment and extensive education about all pelvic floor issues regardless of what you may be suffering from to ensure you fully understand all aspects of bladder, bowel and pelvic floor function to prevent any further problems in future years. The physiotherapist at B.A.P tailor the treatments to your specific needs to ensure you are receiving the best possible treatment relevant to your condition. For pelvic floor problems, an internal examination is offered (to adults with their consent). Pelvic floor dysfunction, bladder and bowel problems tend to get worse with aging and menopause and good education can prevent some of these distressing conditions from occurring further down the track.

Please list key goals you would like to address: \_\_\_\_\_

Please tick the following boxes below to indicate whether you do or do not consent to an examination:

- I give consent to having an external and internal examination of my pelvic floor
- I give consent to only having an external examination of my pelvic floor
- I do not give consent to having an external or internal examination of my pelvic floor
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**Collection of Information:** We require your consent to collect personal information about you. Please read the information below. By submitting this form, you agree to these terms.  
I understand I have the right to request access to my information. I understand that I may withdraw my consent for this practice to use, to share and disclose my personal information, except where legal obligation must be met. I understand that I am not obliged to provide any information requested of me, but my failure to do so will compromise the quality of health care treatment given to me.

**Cancellation Policy:**

Please notify us if you are unable to attend your appointment as we often have a waiting list of clients. We require 24 hrs notice either by phone/email/via website, or the full fee will be charged. If we are able to fill your appointment, there will be no charge.

**Privacy Policy:** located below or select link to view <http://buderimadvancedphysio.com.au/privacy-policy/>

**Please tick box to confirm that you have read the above**

**This is NOT a waiver form.** It is part of our “duty of care” to you that we inform you of any material (pertinent) risks associated with professional treatment techniques.

Following the verbal explanation of my examination results and the therapeutic techniques the therapist thinks suit my present condition, I give my consent to treatment. I have the right to decline treatment that the therapist offers me at any time. I give permission to the therapist to exchange information with my doctor and other medical specialists when necessary. I understand that this information will be confidential.

**I have read this form, understand the information it contains, and give my consent to treatment.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

The above must be at least 18 years of age, otherwise consent from a custodial parent/guardian is required to treat a minor.

Patient Name: .....

Date: .....

Parent/Guardian Name: .....

Date: .....

# **B.A.P Privacy Policy 2020**

## **Our commitment to your privacy**

We are committed to handling personal information about you, including health information about you, in accordance with the requirements of the Commonwealth Privacy Act 1988.

In this Policy, we explain:

- what kind of information we collect and hold about you
- how and why we collect it
- what we do with that information and who we share it with (and when)
- your right to seek access to, and if required correction of, the records we hold about you
- your right to make a privacy complaint, to us and others
- whether we are likely to disclose information about you to overseas recipients.

## **What kind of personal information do we collect about you?**

We collect and hold the following kind of information about you:

- your name, address, date of birth, email and contact details
- information about your family or relatives
- information about other health professionals involved in your care
- any government identifiers such as Medicare number, DVA number. However, we do not use these for the purposes of identifying you in our practice
- other health information about you such as: a record of your symptoms, your relevant medical history, the diagnosis made and the treatment we give you:
  - specialist reports
  - test results
  - your appointment and billing details
  - your prescriptions
  - your healthcare identifier
  - your health fund details
  - other information about you collected for the purposes of providing care to you.

## **How do we collect and hold your personal information?**

We will generally collect personal information about you in these ways:

- directly from you when you give us your details (eg, face-to-face, over the phone, via registration form or an online form)
- from a person responsible for you
- from a third party where we are permitted by law to do that (eg. other health care professionals involved in your care, from your health insurer, Medicare etc).

## **Why do we collect and use information about you?**

We primarily collect and use personal information about you to provide our physiotherapy services to you and to communicate with you and others involved in your care in relation to those services.

We also sometimes use that information for other purposes, including:

- to help us manage our accounts and administrative services, including billing, arrangements with health funds, pursuing unpaid accounts, management of our IT systems and
- to conduct accreditation, quality assurance or internal audits.

## **When and why might we share information about you with others?**

We may disclose information about you to others outside of our practice as permitted or required under law. This will include situations where we disclose information about you in order:

- to comply with our legal obligations (eg. mandatory reporting under legislation, responding to a court order or subpoena)
- to consult with other health professionals involved in your healthcare
- to get test results from diagnostic and pathology services
- to claim on insurance
- to communicate with your health fund, with government and other regulatory bodies such as Medicare
- to help us manage our accounts and administrative services (eg. billing or debt recovery, arrangements with health funds, pursuing unpaid accounts etc.)
- to lessen or prevent a serious threat to a patient's life, health or safety or a serious threat to public health or safety
- to help in locating a missing person
- to prepare the defence of anticipated or existing legal proceedings
- to discharge notification obligations to liability insurers.

## **Your right to seek access to and to seek correction of the information we hold about you**

You have the right to seek access to and correction of the personal information we hold about you.

We will normally respond to your request within 30 days. To make the request, you should contact the Office Manager. B.A.P has an information request form that needs to be completed.

If you think that the information we hold about you is not correct, let us know in writing. We will take reasonable steps to correct your personal information where the information is not accurate or up-to-date. From time to time, we may also ask you to verify that the information we hold about you is correct and current. And please notify us if and when your contact details change (see 'how to contact us').

### **Security: how we hold your personal information**

We take reasonable steps to protect the information we hold about you. These are designed to prevent unauthorised access, modification or disclosure and to prevent misuse and loss.

This includes:

- holding information on an encrypted database
- getting staff to sign confidentiality documents
- providing staff with training or induction etc. about confidentiality and (in particular) security issues
- access to information restricted on a 'need to know' basis and
- strong password protections when accessing the information on a computer.

## **Your right to receive treatment from us anonymously (or by using a pseudonym)**

Where it is lawful and practicable for us to do so, you can be treated anonymously or through use of a pseudonym (a name other than yours).

### **Disclosing information about you overseas**

We do not propose to disclose information about you to anyone overseas. If we want to transfer your personal information overseas, we will first seek your consent, unless we are required by law to do the transfer.



## **If you have a privacy-related concern about us**

If you have concerns about the way we've handled your privacy, let us know. You should do that in writing. We will then try to respond to you within 30 days.

If you are not satisfied with our response, you can refer your complaint to the Office of the Australian Information Commission, whose contact details are:

Phone: 1300 363 992

Email: [enquiries@oaic.gov.au](mailto:enquiries@oaic.gov.au)

Post: GPO Box 5218 Sydney New South Wales 2001 Website: <https://www.oaic.gov.au/privacy/privacy-complaints/>

## **Updating this policy**

We will update this policy from time to time, to reflect any changes in our information-handling practices or the law or both.

We will notify you of changes to the policy by our website and Practice information sheet.

## **How to contact us**

To contact us about any privacy related issues, please approach the receptionist at the front desk or send an email [admin@buderimadvancedphysio.com.au](mailto:admin@buderimadvancedphysio.com.au)