Treatment Consent Form

Title		DOB:	
Full Name			
Address			
Postal Address (if different)			
Home Phone:		Mobile:	
Email		Work:	
Occupation			
Usual GP			
Medical Practice			
Ethnicity			
Are you a member with Southern Cross Insurance?		Member Number:	

PRIVACY ACT:

In accordance with the PRIVACY ACT 2020 and the Health Information Privacy Code all information recorded in your health records will be kept confidential. Your record will only be accessed by the clinicians providing your care and our administration staff. All personnel in this practice are bound to maintain strict patient confidentiality. No information will be given to a third party other than ACC, your workplace insurer, your usual doctor, or the clinician referring you to Sports Doctors without your written permission.

You agree to notify Sports Doctors of any change to your personal details as noted above.

CONSENT TO TREATMENT

I consent to treatment, bearing in mind that a full verbal explanation will be given at the time of treatment. I have the right to decline part, or all of the treatment given or offered to me.

I understand that my treatment provider may discuss my treatment or seek advice from another medical provider in order to give the best possible care. I understand that they may need to access my notes and consent to the release of information in this instance.

CONSENT TO REQUEST NOTES

To ensure full and accurate treatment information for optimal shared care, I, _____ consent to Sports Doctors requesting my medical records only in regard to the injury or condition I am receiving treatment for. I acknowledge that these are to be sent to Sports Doctors and will be kept confidential.

Treatment Consent Form

AGREEMENT TO PAY

I understand that I am liable to pay at the time of treatment for:

Any ACC co-payment charges, any private treatment costs and the costs of any materials used to treat me such as cortisone, strapping tape, braces etc. Failure to do so may incur account administration fees. If I fail to attend my appointment or give less than 4 hours' notice when cancelling, I may be charged a non-attendance fee.

I understand that if Sports Doctors need to engage a debt recovery service to recover my debt, I will be liable for any recovery fees

I understand that if ACC decline to cover any injury or treatment then I am liable for the treatment costs.

ACC INJURY CLAIM DECLARATION

I declare that the information I give about any claim is true and correct and I will not withhold any information likely to affect my application.

I will inform ACC of any change in circumstances which may affect my entitlements.

I authorise the collection and disclosure of any information about me to the extent necessary to determine cover and/or assess my entitlement to compensation, rehabilitation assistance, medical treatment, and/or the appropriate level of care and personal attention that I should receive and/or to assist the evaluation of services and the performance of the ACC scheme and/or to support the administration of the Health and Safety at Work Act 2015.

I authorise the clinician to lodge this and any subsequent claims on my behalf. A copy of any claim is available from my provider.

Signed: _____ Date: _____

(By Parent/Guardian if under 16 years)