re-wired hand therapy
& nerve recovery

Patient Registration Form

Please complete the following information for our confidential records.

Patient Surname: (Mr/ Ms/ Mrs/ Miss/Mst)_____

Patient Given Name/s: _____ **D.O.B**: __ /__ /__

Address: _____ **Suburb**: _____ **Postcode**: _____

Telephone Home: _____ Work: _____ Mobile: _____

Parent/Guardian Name & Mobile (where under 18 years of age): _____

What style of consultation do you prefer? TeleHealth (Skype) / Telephone / Face to Face in Clinic

Email Address: _____

(this is our best way of communication so please ensure where possible you fill in the email address)

Referring Doctor	**Local Doctor (if different)**
Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____	Phone: _____

Date of injury: __ /__ /__ **Date of surgery**: __ /__ /__ **Date of referral**: __ /__ /__

Do you have Private Health Insurance: Yes ❑ No ❑ **Fund Name:** _____

Are you a Pension or Health Care Card Holder: Yes ❑ No ❑

Are you a <u>Veteran</u> GOLD Card Holder (DVA): Yes ❑ No ❑ **Card Number:** _____

Is this related to a <u>Work Accident Claim</u>? Yes ❑ No ❑ **If Yes, Please complete details below**

Employer Details	**Insurance Details**
Name: _____	Insurer: _____
Address:_____	Claim Number: _____
Email: _____	Case Manager: _____
Phone: _____	
Contact Person: _____	

Is this related to a <u>TAC</u> claim? Yes ❑ No ❑

Claim Number: _____	Date of Accident: __ /__ /__

Conditions

1. I agree to release of relevant medical information to the referring doctor and other health professionals involved in my care.
2. I understand that there are limitations with Telehealth consultations and that Re-wired Hand Therapy are offering this as an alternative to a Face to Face consultation with your consent, because of the increased risk associated with the COVID-19 Virus.
3. I understand that Re-wired Hand Therapy is a trading name of the Therapist's Choice Pty Ltd and the Sunbury clinic is owned by High Five Healthcare Pty Ltd, operating under a licence agreement with Re-wired Hand Therapy.
4. I understand and agree that items provided will incur a delayed payment surcharge unless paid for on the day of service.
5. I agree to pay all accounts within 7 days from the invoice date or a $10 administration fee will apply to each invoice.
6. I agree to pay all costs associated with any debt collecting and/or legal expenses applicable to my accounts.
7. I have read and agree to the fee policy.

Signed: _____ **Date:** _____/_____/_____