Patient Registration Form

To be completed and signed by Parent/Guardian if under the age of 18

Please complete the following information for our records. This information remains confidential.

Surname: (Mr/Mrs/Ms/Miss/Mst) _____ **First Name**: _____

Address: _____ **Suburb**: _____ **P/code**: _____

Telephone: M: _____ H: _____ W: _____

D.O.B: _____/_____/_____ **Sex:** ❑ Male ❑ Female

Email Address: _____

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

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

Are you a Pension or Veteran Card Holder: Yes ❑ No ❑ **Card Number:** _____

Medicare Card Number: _____ **Ref:** _____ **Expiry:** _____

Workcover Details

Employer Details	Insurance Details
Name: _____	Insurer: _____
Address:_____	Claim Number: _____
_____	Case Manager: _____
Phone: _____	
Contact Person: _____	
Date of Injury: _____/_____/_____	Date of Surgery: _____/_____/_____

TAC Details

Claim No: _____ /_____	Date of Accident: ____/____/_____	Date of Surgery: ____/____/_____

Conditions

1. I agree to release the relevant medical information to the referring doctor and other health professionals involved in my care.
2. I agree to give 2 business days' notice of any appointment cancellation or pay a $30 cancellation fee.
3. A cancellation fee will be charged personally to Workcover and TAC patients where 2 business days' notice is not given.
4. I agree to pay all accounts within 7 days from the invoice date or a $20 administration fee will apply to each invoice.
5. I agree to pay any additional costs associated with any debt collecting and/or legal expenses applicable to my accounts.
6. I have read and agree to the fee policy.
7. I have read and agree to the Action Rehab Terms of Service.
8. I have been made aware of the Privacy Policy.

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