Patient Intake Form

If you require assistance, please do not hesitate to ask.

www.ethoshealth.com.au

Patient Details:

Title: Mr / Ms / Mrs / Miss / Dr		
First Name:	**Surname:**	D.O.B:
Address:	Suburb:	Post Code:
Phone: (H)	(W)	(M)
Email:	Occupation:	
What is the reason for your appointment?		

Physiotherapist/Exercise Physiologist only:

Please provide injury information below if applicable	
Body Area/s Injured:	Date Of Injury / Recurrence:

GP/Treating Doctor Details:

Doctor Name:	Phone:
Address:	Date of Referral:

Referrer (How did you hear about Ethos Health?)

GP/Treating Dr	☐	Employer	☐	Family/Friend*	☐	Other _____
Specialist	☐	Rehab Provider	☐	Sports Club	☐	
Radio	☐	Web	☐	Yellow Pages	☐	
Referrer Name:						
Referrer Address:						

*Family/Friend referrers will receive a **$20 Ethos Health gift voucher** if contact details are provided.

This section is ONLY required for insurance claims.

Employer Information:

Employer:	HR/Return to Work Contact:	
Address:		Post Code:
Suburb:	Phone:	Fax:

Insurance Information:

Insurer:	Claim Number:	
Case Manager:	Phone:	Fax:

Rehabilitation Information: (if available)

Rehab Provider:	Phone:	Fax:
Case Manager:		

ethos HEALTH

www.ethoshealth.com.au

Consent to Release Information

I authorise Ethos Health to obtain, release or discuss information, either written or verbal, concerning relevant aspects of my treatment program, with representatives of the following agencies:

☐ Insurer ☐ Employer ☐ Referring GP
☐ GP ☐ Rehab Provider ☐ Specialist

Other: _____

Please read the following information carefully and tick, sign and date where indicated.

☐ I understand that I may change or cancel the authority to obtain or release information.
☐ I understand that if my claim is denied I will be responsible for treatment expenses.
☐ I understand that any expense, costs or disbursements incurred by Ethos Health in recovering any outstanding monies including debt collection fees and solicitor costs shall be paid by I (patient), providing that those fees do not exceed the scale charges as charged by that debt collection agency/solicitor plus any out of pocket expenses.
☐ I understand that I (patient) may be responsible for the payment of a cancellation fee if my appointment is cancelled with less than 24 hours notice.
☐ I understand the terms and conditions of attendance and agree to abide where possible.
☐ I would like to receive information from Ethos Health including special promotions and offers.

Client Name: _____ DOB: ____ / ____ / _____

Signature: _____ Date: ____ / ____ / _____
*Clients under the age of 18 require a signature by a parent/guardian

Parent/Guardian Name (if applicable): _____

Office Use only

W/C / Private / Medicare

File #: ___ ___ ___ ___ ___ Date: ___ ___ / ___ ___ / ___ ___ ___ ___ Admin: ___ ___ AHP: ___ ___

Outcome Information:
Ax DOR: DOA: Quest Type: VAS RTW Code PID/SD/Unfit/Referred/ D/C
D/C DOD: No of Rx's: Quest Type: VAS RTW Code PID/SD/Unfit/Referred/ D/C

Exercise Physiology:
DOI: DOD:
No of Rx's: RTW Code PID/SD/Unfit/Referred/ D/C

LOCATIONS:

Head Office
1/8 Denison Street
Newcastle NSW 2302
T (02) 4962 8700
F (02) 4962 8702

Newcastle
8 Denison Street
Newcastle NSW 2302

Lake Macquarie
Suite 7, Level 2 Lake Macquarie
Specialist Medical Centre
6-8 Sydney Street
Gateshead NSW 2290

ALL CLINICAL CORRESPONDENCE:
8 Denison Street
Newcastle West NSW 2302
T (02) 4962 8700
F (02) 4962 8701
E enquiries@ethoshealth.com.au