Office Use Only:
ACC 45#:

MERIVALE PHYSIOTHERAPY CLINIC Registration & ACC Information Form

LAST NAME: **Mr/Mrs/Ms/Miss/ Other please state**	**FIRST NAME:** **PREFERRED NAME:**	**E-MAIL ADDRESS** **NHI Number if known:**
OCCUPATION:	**DATE OF BIRTH:**	☐ **MALE** ☐ **FEMALE**
	ETHNICITY: e g NZ European, Maori, Chinese etc. **Do you have any special cultural needs we need to be aware of?**	
CELLPHONE:	**HOME PHONE:**	
STREET ADDRESS:		
SUBURB:	**CITY:**	**POST CODE:**
POSTAL ADDRESS:		**POST CODE:**
NAME OF GP:	**MEDICAL PRACTICE:**	

WHO REFERRED YOU TO MERIVALE PHYSIOTHERAPY? ☐ **GP/Specialist – if Specialist, name:**
☐ **Been Before** ☐ **After hours clinic** ☐ **Family/Friend** ☐ **Yellow/White Pages** ☐ **Internet** ☐ **Signage** ☐ **Other……**

SECTION 2 – GENERAL HEALTH QUESTIONNAIRE:

☐ Pregnant	☐Osteoporosis	☐ Asthma/Respiratory/Hyperventilation	☐ Circulation
☐ HIV/Hep C	☐ Cancer	☐ Continence Issues	☐ Hearing/sight impaired
☐ Osteoarthritis	☐ Allergy (Specify)	☐ Stress/Anxiety	☐ Physical disability (Epilepsy)
☐ History of Falls	☐ Diabetes	☐ Blood Pressure/Heart/ Pacemaker/surgeries	☐ Intellectual Disability

MEDICATIONS – PLEASE LIST:

SECTION 3 - ACC CLAIM INFORMATION ***(Do Not Complete if Private Patient)***

☐ **ACC – Claim Already Registered elsewhere** **Please advise if you need us to call ACC for the details.**	**ACC CLAIM NUMBER:**	☐ **ACC- New Injury Claim** **(i.e. not already registered elsewhere)**
Did your injury happen at work? ☐ **Yes** ☐ **No**	**IF YES, EMPLOYER NAME, POSTAL ADDRESS, PH etc.** **WORK INTENSITY:** ☐ **Sedentary** ☐**Light** ☐**Medium** ☐**Heavy** ☐**Very Heavy**	

DATE OF INJURY:	**TIME OF INJURY:** ***(approx.)***	**Location:** ***e.g. Christchurch***	**Scene:** ***e.g. Home, Work, Sport, School, Vehicle, Other***

CAUSE OF INJURY: Describe what you were doing and where your injury is ***e.g. Lifting heavy box and twisted right wrist etc.***

READ CODES:
(staff use only)

Have you ever received any previous physiotherapy treatment for this condition? ☐**Yes** ☐ **No**

SECTION 4 - CONSENTS

I hereby agree to consent to treatment by an appropriately qualified physiotherapist for the purpose for providing comprehensive physiotherapy services as may be necessary in support of my illness, injury or condition. I have been given the opportunity to read clinic information prior to treatment. I understand I have the right to decline part or all of the treatment being offered. I understand my right to a second opinion.

AGREEMENT TO PAY:

I understand that I am liable to pay for:

- Treatment if it is not covered by ACC
- Any treatment that is declined by ACC or other funder
- The costs of materials such as, splints, tape etc. if not covered by ACC
- If I fail to attend or cancel my appointment within 4 hours, I will be required to pay a non-attendance fee (details at reception)

I understand that if this service requires to engage a Debt Recovery Service to recover my debt, I will be liable for any recovery fees.

CONSENT TO RELEASE INFORMATION TO A 3rd PARTY

I consent to the disclosure of my records to any person/organisation necessary for the effective management of my condition.
I consent to a discharge/update report being sent to my doctor or medical centre.

PATIENT DECLARATION AND CONSENT

I have read and understood the Important Information, Patient Declaration and Consent on the reverse of the patient copy of this form.

SIGNED: **DATE:**

(If under 16 must be signed by parent/guardian)

Case History

Merivale Physiotherapy wishes to provide a comprehensive solution to your condition. Please complete this to help us understand your injury/condition.

What is your main problem?

……

How long have you had this issue?

……

Is it new or a recurrence?

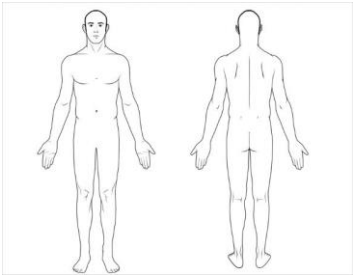
……

Any previous injuries

……

Please draw on body site of problem

Body picture



Pain Information: (circle appropriate) **Constant /Comes and goes**

(circle appropriate) **No Pain / 0 1 2 3 4 5 6 7 8 9 10 / Worst Pain Imaginable**

Types of Symptoms: Sharp Travels Achey Radiates Shooting Throbs

Sensory Symptoms: Pins and needles Tingling Numbness Weakness/Giving way Other……

My Symptoms are currently: About the same Improving Worsening Up and down Other……

What makes your symptoms worse? Sitting Standing Walking Standing from a chair Stairs

Arm use Neck movements Bending Leisure/Sport Work Sleep Hobbies

Other……

24 Hour Behaviour: Does it interfere with your ability to Sleep Yes No

Are the symptoms present on waking? Yes No

If not present on waking, when do the symptoms first appear?

…… ……

Please identify 3 important activities that you are unable to do or have difficulty doing as a result of your injury/ problem using the scoring system below

Unable to perform **0 1 2 3 4 5 6 7 8 9 10** perform at the same level as before your injury/problem

Activity	0 - 10

Have you had **(please circle if YES)?**

Spinal fracture Spinal Surgery Dislocations Ligamentous Injuries Cartilage injuries

Work Duties:

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ACCIDENT COMPENSATION CORPORATION

CLIENT INFORMATION FORM

This form is the first step in getting help from ACC if you've been injured in an accident. ACC does not cover illness or a medical condition or conditions resulting from age, degeneration. The form collects all of the basic information we need about your injury to help us decide if we can provide cover. If we need any more information about this claim we will contact you later.

ACC is here to help when you've suffered an injury. Once cover has been established (that means that you have an injury which ACC has accepted) we'll help towards the cost of your initial medical treatment, including GP costs, X-rays, physiotherapy, etc. This means it's important that all the information on this form (ACC45) is accurate to make sure that you receive the right treatment and payments for this claim.

ACC will pay a fee direct to your treatment provider for your medical treatment. Your treatment provider may have charged you an extra amount (surcharge) above the amount ACC can pay. We are not able to reimburse you for that surcharge.

ACC may be able to assist you with other types of help depending on your needs. But you must apply for this assistance. Please contact us on 0800 101 996 to get our approval before you incur costs that you expect ACC to pay.

You can apply for the following types of assistance:

- Medical assistance, including medical treatment, dental treatment, further courses of treatment and travel to treatment.
- Social rehabilitation assistance to help restore your independence, such as home help, childcare, attendant care, a wheelchair, home modifications and education.
- Vocational rehabilitation assistance to help you keep your job, find a new job or regain vocational independence. This support can include such things as assessment of your vocational needs, modifications to your work site, work trials and assistance with finding a new job.
- Financial assistance, such as weekly earnings compensation, or lump sum compensation.

If you would like to know more about the claims process or any other ACC service, please call 0800 101996

PATIENT DECLARATION AND CONSENT

I declare:

- That the information given in this form is true and correct and that I have not withheld any information likely to affect my application. I will inform ACC of any changes 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 assessment entitlement to compensation, rehabilitation assistance, including 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 & Safety in Employment Act 1992.
- The collection and disclosure of information for the purposes of research into injury prevention and effective assessment and rehabilitation.
- The treatment provider to lodge this claim for me.

I understand

- That this authority relates to all aspects of my claim and authorises ACC to contact anyone who holds relevant information, including any external agencies or service providers (such as medical practitioners, specialists, New Zealand Police, Occupational Safety & Health, treatment providers, IRD, Work & Income, assessment agencies, employers and witnesses to the accident).
- That the information collected on this form will only be used or disclosed in relation to the purposes of the Injury Prevention, Rehabilitation and Compensation Act 2001. In the collection, use, disclosure and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994.
- That I have the right to see, and as for correction of any information that ACC holds about me.
- This form may be used by accredited employers in these cases where ACC is specified in the patient declaration this should be read as applying to the accredited employer managing the claim.

This information collected by ACC in this form (ACC45) and at other times will be used to process this claim in accordance with the authority and understanding set out above, and in accordance with the Privacy Act 1993 and Health Information Privacy Code 1994. The Privacy Act gives you the right to see and correct personal information ACC holds about you.