Patient Intake Form

Patient Details:

First Name:	**Surname:**	D.O.B:
Address:	Suburb:	Post Code:
Phone: (H)	Parent/Guardian (M)	
Parent/Guardian Email:		
Body Area/s Injured:	Date Of Injury / Recurrence:	
Sporting Code:	Player Position:	

GP/Treating Doctor Details (if known):

Doctor Name:	Phone:
Address:	Date of Referral:

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:

☐ School ☐ Referring GP ☐ Specialist
☐ GP ☐ Coaching Staff

Other: _____

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

☐ **I understand that I am responsible for treatment expenses $35 which are payable on the day**.
☐ 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 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: ____ / ____ / _____

Student Signature: _____ Date: ____ / ____ / _____

Parent / Guardian Signature: _____ Date: _____ / _____ / _____

Office Use only:

Private / Non- HF

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