Consent and Information Form

Date:___/___/___
Please take a few minutes to answer the following questions.
Name:_____DOB:_____
Address:_____
Email:_____
Mobile:_____Home Ph:_____
Medicare Number:_____/_____Health Fund:_____
Doctor's Name:_____
Clinic/Suburb:_____

Do you have a health care card?	
Are you a pensioner?	
Do you have a Veterans Affairs Card?	
Do you have a GP management plan from your GP?	
Do you have health insurance?	

How did you hear about us?
Physio_____ Doctor_____
Buzz magazine_____ Word of mouth_____
Other_____

Cancellation Policy:
We ask that you provide 2 business days' notice if you are unable to attend your appointment. Please call us to ensure we receive your message. We do understand some situations will prevent you from providing adequate notice. Should you fail to attend your consultation without contacting us with appropriate notice a cancellation fee will be applied.

Communication:
Do you consent to being contacted by True North Wellness by phone, text message or email with regards to your appointment and consultation information? Yes ☐ No ☐

Confidentiality:
Do you give consent to us to contact your GP? Yes ☐ No ☐
Is there any other health professionals you would like to be informed in regards to your treatment? Yes ☐/No ☐Provider/s_____

Signed_____ Date___/___/___