HOMEPHYSIO
MELBOURNE

ACKNOWLEDGEMENTS, FINANCIAL RESPONSIBILITY, CANCELLATIONS

"We": refers to Home Physio Melbourne Pty Ltd, Benjamin Gold or affiliates. "I" refers to any individual receiving treatment by Home Physio Melbourne Pty Ltd, Benjamin Gold or affiliates.

Patient Data Form and Privacy Laws

Patients are required to complete the enclosed form. The collection of this information is essential for clinical and administrative reasons. All collected information will be held and disclosed in compliance with the Health Records Act (VIC) 2001. All patients are kindly asked to carefully read and sign CONSENT for COLLECTION OF PERSONAL INFORMATION

Release of Information

I give authority to this medical provider to collect and hold my personal information in accordance with the privacy act. I am aware that this information may be shared with others involved in your health, including treating doctors, specialists, radiology, physiotherapists, podiatrists, exercise physiologists outside this practice.

I understand that I am not obliged to provide any of the information requested of me, but that my failure to do so might compromise the quality of the health care provided to me

Guarantee of Payment/Financial Responsibility/Insurance

I agree to pay **Home Physio Melbourne Pty Ltd** in full at the end of each treatment session, unless otherwise agreed upon by both parties in writing.

I understand that any balance after insurance reimbursement is my/our responsibility. I agree to pay the balance within 14 days of receipt of invoice. **Late payments will incur a weekly 5% interest**

Cancellations

I understand that if I am unable to attend a scheduled appointment, I am required to cancel the appointment by email or call 24 hours prior to the said appointment; otherwise a fee of 50% of the agreed appointment fee will be incurred for late cancellations. This fee is not reimbursable by insurance.

Consent

By signing my name below, I verify that I have read and agree to the information contained in this document and the information I have provided is true and accurate.

Patient's signature
(or responsible party if the patient is a minor or unable to sign. Include relationship)

Date of Birth:

Date: