UP & RUNNING PODIATRY

**Podiatrists**
Gary Johnstone B.Pod
Matthew Bull B.Pod (Hons)
Madeleine Murray B. Pod (Hons)
Stephanie Melitsis M. Pod Prac/B.HS
Alec Hill BHSc Pod

| PATIENT INFORMATION | | | |
|---|---|---|---|
| TITLE: | FIRST NAME: | SURNAME: | DATE OF BIRTH: |
| ADDRESS: | | | POSTCODE: |
| MOBILE: | | HOME PHONE: | |
| EMAIL ADDRESS: (important for appt. reminders) | | | |
| NAME OF PARENT/GUARDIAN IN CHILD IS UNDER 18: | | EMERGENCY CONTACT NAME AND NUMBER: | |

| MEDICAL HISTORY/ALLIED HEALTH NETWORK | | | |
|---|---|---|---|
| NAME AND LOCATION OF GP: | | | |
| PLEASE TICK ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU HAVE. | ☐ Diabetes<br>☐ High blood pressure<br>☐ Arthritis | ☐ Heart conditions<br>☐ High cholesterol<br>☐ Blood clotting/ DVT | ☐ Kidney condition or failure<br>☐ Allergy to tape/Band-Aids |
| OTHER (please specify): | | | |
| LIST ANY ACTIVE MEDICATIONS: | | | |
| DO YOU SEE ANY OF THE FOLLOWING? | ☐ Physiotherapist<br>☐ Osteopath<br>☐ Myotherapist | ☐ Chiro<br>☐ Exercise Physiologist<br>☐ Dietician/Nutritionist | ☐ Occupational Therapist<br>☐ Psychologist<br>☐ Other: |
| PLEASE PROVIDE US WITH THE NAME AND CLINIC DETAILS OF YOUR SELECTED HEALTH PROFESSIONAL TEAM AS ABOVE. | | | |
| ARE YOU SEEING US AS A WORK COVER/TAC CLAIM?<br>☐ Yes ☐ No | ARE YOU SEEING US UNDER THE DVA SCHEME?<br>☐ Yes ☐ No | DO YOU HAVE A CARE PLAN FROM YOUR GP?<br>☐ Yes ☐ No | DO YOU HAVE PRIVATE HEATLH INSURANCE?<br>☐ Yes ☐ No |

| GENERAL INFORMATION | | |
|---|---|---|
| What is your occupation? | | |
| How did you hear about us? | ☐ Doctor/ health professional ☐ Word of mouth ☐ Sporting Club ☐ Google<br>☐ Signs/ passing by ☐ Facebook/Instagram ☐ Yellow pages<br>☐ Other (please list): | |
| List any sports you undertake: | | How many KM's do you run/walk each week? |

**Patient Consent to Release of Information**

All patient information is considered confidential and used solely for the purpose of providing the best care, to get you moving and feeling better. Up and Running Podiatry may have to contact some (or all) of the following people to allow successful injury recovery and payment of accounts.

- Physician, specialist, insurance company
- Work Cover and employer (for Work Cover claims only)
- Insurance adjuster and/or lawyer (for car accident claims only)

I agree to let Up and Running Podiatry communicate as needed with individuals indicated above regarding my care and payment of my account.

Signature: _____ Date: _____

**Payment and Cancellation Policy**

- Payment is to be collected at the end of each treatment
- We do directly bill certain insurance companies with prior approval. It is your responsibility to keep track of the treatments you attended so that you do not exceed your coverage. Please check with your insurance provider. Any payment not covered by an insurance company/ Medicare will be your responsibility
- For TAC claims, if they refuse to pay you will be responsible for the cost of the treatment
- If Work Cover claims are disallowed you will be responsible for the cost of treatment
- **If you miss or cancel an appointment with less than 24 hours of notice you will be charged 50% of the cost of the treatment.** Medicare, employers, Work Cover and TAC do not pay for missed appointments so you will have to pay the cost personally
- **All appointment changes are required to be made over via phone. Changes by text or email will be invalid.**

I understand and consent to the payment and cancellation policy.

Signature: _____ Date: _____