



Neurological/Community Physiotherapy Services Consent and Agreement to Pay

PATIENT PERSONAL INFORMATION:	
Full name:	
Name you go by:	
NHI:	
DOB:	
Address:	
Mobile:	
Email address:	
GP:	
Medical Centre:	
Specialist (if applicable):	

NEXT OF KIN / EPOA / WHANAU EMERGENCY CONTACT <i>Please list multiple if appropriate</i>	
Name(s):	
Contact number(s):	
Relationship(s):	

Please indicate below who to send the invoice to:	
Name and relationship to client:	
Email address or billing address (preferably email):	

SERVICE FEE (GST INCLUSIVE)	
Private Initial Assessment \$ 190	Private Follow-Up \$ 160

*Travel is included unless stated. Any extra travel charges will be agreed prior to initial visit

CONSENTS AND AGREEMENT TO PAY

- I consent to being assessed by a registered Physiotherapist
- I understand that I will be fully informed and need to give consent prior to any treatment
- I consent for my condition to be discussed with my GP or other relevant Health Professionals, or persons as clinically indicated
- I consent to the Physiotherapist reading my facility notes and talking to appropriate staff to gain further relevant information (if in a residential facility)

I understand that I will be liable to pay:

- Private treatment fees
- If I do not attend my appointment or cancel within 6 hours, I may be charged \$50
- If I fail to pay my invoice for my appointments by the date specified on the invoice, I may be charged an extra administration fee of \$50

I have read and understood all the information above

Signed: Client (Next of kin / EPOA / Whanau if required) _____

Date: ____/____/____

For all enquiries, please contact us on **04 384 8313** or info@willisstreetphysiotherapy.co.nz

Remittance Advice

Willis Street Physiotherapy

PO Box 11351
Manners Street
Wellington 6142

Credit Bank: ASB

Account Name: Willis Street Physiotherapy Ltd

Account No: 12-3192-0054006-00

When making payment, please use both your invoice number and surname as a reference