

INFORMED CONSENT

Physiotherapy and Exercise Physiology treatment are generally effective and safe forms of treatment, however like any treatment there are benefits and risks. The purpose of this form is to let you know what your rights are and how we address the issue of collaborative decision-making and informed consent between you and your clinicians.

Your clinician will discuss your condition and options for treatment with you so that you are appropriately informed and can make decisions relating to treatment. You may choose to consent to or refuse treatment for any reason including religious or personal grounds. Once you have given consent you may withdraw it at any time.

Please read the following and sign below:

Your clinician may ask personal questions in relation to your injury/medical condition and how your symptoms impact on your activities of daily living. The more information you provide the more likely it is that the clinician can provide an effective treatment and recommendations. It is your choice as to what information you choose to provide.

During the examination, assessment and treatment it may be necessary for your clinician to make physical contact. Where ever necessary, contact will be made with a towel or other form of screening. Physical contact requires your express consent. You may withdraw consent at any time at which point all physical contact will cease immediately. Please inform your clinician if you feel uncomfortable at any time.

Acupuncture treatment is used in this clinic. It is a form of therapy in which fine needles are inserted into specific body points. Acupuncture is generally safe with serious side effects less than one per 10,000 treatments. Common side effects include drowsiness, minor bleeding (3%), pain during treatment (1%), transient increased pain after treatment (3%) and fainting. If acupuncture is provided to your trunk there is a possibility of a pneumothorax and your physiotherapist will seek your consent before this treatment is provided. Single use, sterile, disposable needles are only used in this clinic. Allergic skin reactions to massage oils, strapping tapes or acupuncture needles are a possibility. Electro-physical agents such as ultrasound or interferential therapy have been linked to minor burns and abnormal skin reactions.

Your physiotherapist will discuss any specific foreseeable risks associated with treatment options prior to commencing your treatment and ask for your consent. You may withdraw your consent at any time.

Your **Personal Health Information and your Health Record** may be collected, used and disclosed for the following reasons:

- For communicating relevant information with other treating physiotherapists, doctors or allied health professionals
- Accounting / Medicare / Health Insurance procedures
- Quality Assurance activities such as accreditation
- For disease notification as required by law (e.g. infectious diseases)
- For use by all clinicians in this practice when consulting with you
- For legal related disclosure as required by a court of law.
- For research purposes (de-identified, meaning you are not able to be identified from the information given).

If you have any concerns or wish to restrict access to your personal health information please discuss these with your clinician or administration. This practice adheres to **National Privacy Principles** (www.privacy.gov.au) and has a written policy, which is available to all clients for inspection.

Consent from a **custodial parent** is required to treat a minor. We recommend a family adult be present during treatment. Where a person is incapable of understanding the risks and benefits of treatment consent may be provided by another person legally authorised to provide such consent. Evidence of legal authorisation is required.

Informed Consent

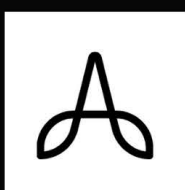
I _____ have read and understood the statements above relating to consent. I offer consent to receive treatment within this clinic. I agree to this consent remaining valid until such time as I withdraw my consent.

Signed _____ Date _____

Account Responsibility

I _____ acknowledge responsibility for my accounts and understand I may be liable charged a fee for overdue accounts. Appointments cancelled with less than 24 hours notice may incur a cancellation fee.

Signed _____ Date _____



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