



working
with you
for you.

Corio Bay Health Group - Geelong New Patient Registration

Date: ____ / ____ / ____ Physio / Doc: ____

YOUR DETAILS

Mr / Mrs / Ms / Miss Surname: _____

Given Name/s: _____ Date of Birth: ____ / ____ / ____

Phone (H) _____ (W) _____

(M) _____ Email: _____

I do not wish to receive updates and information at my e-mail address from Corio Bay Health Group

Postal Address: _____

Suburb: _____ Postcode: _____

Occupation: _____

Treatment today is required on which part of your body: _____ (not required for doctor appts)

I am a **player, staff** or **committee** member of a local sporting club.

Club Name _____

ACCOUNT DETAILS

I will be paying for my account privately

I have a **pension** or **health care card**

Please note: **health care cards** are issued by centrelink and are separate to private health insurance.

Number: _____ Expiry Date: ____ / ____ / ____

Please note that **all accounts are to be settled at the time of consultation**. If you are unable to pay for today's treatment you must notify reception staff prior to your appointment.

I am a Veteran's Affairs White Card or Gold Card Holder

Card Number _____

Please note You must have a current doctor's referral in order to claim through DVA.

This is an approved Workcover Claim **Complete Section 1 overleaf**

This is an approved TAC Claim **Complete Section 2 overleaf**

REFERRAL SOURCE

How did you hear about Corio Bay Health Group?

Practitioner Referral Name: _____ Clinic: _____

Advertisement

Sporting Club

Clinic Signage

Website / Internet

Friend / Family Member

Word of mouth

Personal Trainer / Gym

Yellow Pages / Sensis

Other: (please specify) _____

SECTION 1: NEW WORKCOVER CLAIM

DECLARATION

I _____
(Full Name)

Of _____
(Address)

Hereby claim that on _____ / _____ / _____ I was involved in a work related incident. I furthermore acknowledge that in the event that my employer rejects this claim, I will be liable for all medical expenses in relation to this incident.

I agree to settle all accounts on the day of consultation until my employer accepts liability for the workcover claim. I understand that if my employer accepts the claim Corio Bay Health Group - Gee-long (Corio Bay Sports Medicine Centre) will bill my employer directly.

Signed: _____
(Patient's Signature)

CLAIM DETAILS

Claim No: _____ Employer / Company Name: _____

Employer's Billing Address: _____

Contact Person: _____ Telephone _____

Name Of Insurance Company Handling Your Claim: _____ (If applicable)

SECTION 2: NEW TAC CLAIM

Date Of Accident: _____ / _____ / _____ TAC Claim Number: _____ / _____

After your accident were you admitted to hospital as an inpatient? Yes / No

If yes, which hospital? _____

Have you received written confirmation from TAC that you have reached your medical excess? Yes / No

If so, who is your case manager? _____

You are required to pay for your consultations at the time of treatment until you can provide the Corio Bay Sports Medicine Centre with written confirmation from TAC accepting your claim and that your medical excess has been reached.

I understand these terms and agree to abide by them.

Signed: _____ Date: _____ / _____ / _____

Office Use Only:

Claim Approved Denied

Date: ___ / ___ / ___

Authorising Person: _____

Company Name: _____

Position: _____

Staff Initials: ___ Signature: _____