

Patient Details and

Agreement to Partake in Oil Dispersion Bath Therapy

Please complete the details below

In accordance with the Commonwealth Privacy Act, your health records and other information held and collected by Louise Schnitzhofer is kept confidential and used only for your healthcare and resulting administration.

Today's Date	
Patient's name	DOB
Guardian's name and relationship	
Postal Address	
Email Address	Phone
Emergency Contact & Phone	
Why have you come for oil dispersion bath therapy?	
Please list the name and contact for all health practitioners (registered or unregistered) that you are seeing or whose advice you are following:	Please list the medicines, treatment, diet etc that you are following from this practitioner:

Please raise anything at all that you feel you need clarified prior to proceeding with the consultation / treatment. Treatments will only go ahead if both Louise as the practitioner and you as the patient have agreed to consult. If at any time during a treatment or consult you change your mind please provide notice immediately. These agreements can be verbal or in writing such as by this form.

Use the space below to write or illustrate anything that cannot fit above or that you would like put in writing.

Please cross out statements that are not true or you do not agree with:

- I am physically capable of entering and exiting the bath without assistance
 - I have read the patient-practitioner guidelines and understand where to access them for future referral
 - I agree to immediately informing Louise directly of anything that I think may have arisen as a result of engaging with this practice
 - I am fully aware of the fees. Please invoice me and I will EFT within 24 hours / I will pay cash today
 - I understand treatment can not go ahead for the following reason(s)
-
- I have provided true and accurate information and agree to receiving an oil dispersion bath with the following conditions

Patient Signature

Date

Louise

Schnitzhofer

Date