Patient Details

theentcentre

PATIENT - ADULT

_____ _____

Title **First Name** **Surname**

ADDRESS:

_____

Suburb _____

State _____ **Postcode** _____

Date of birth_____

Email _____

Home Phone _____

Work Phone _____

Mobile_____

BILLING

Medicare No. _____ **Ref** _____

Private Health Fund _____ **Membership No.** _____

Level of Cover (if known) _____

DVA Card No. _____ **Card Colour** _____

Disability (DVA White card holders only) _____

REFERRAL

Referring Doctor:

_____

Name **Clinic** **Suburb**

General Practitioner (if different from above):

_____

Name **Clinic** **Suburb**

Are there any other medical practitioners you would like to have copied on correspondence apart from your referring doctor and usual GP? Please list below

Name Address/Clinic Phone

_____

_____

EMERGENCY CONTACT

Please tick to consent for your medical information to be discussed with the nominated contact

Name Relationship to you Phone

_____ ☐

_____ ☐

Patient Consent

theentcentre

CONSENT TO ELECTRONIC COMMUNICATIONS

I consent to contact via email and SMS ☐

CONSENT TO COLLECT PATIENT INFORMATION

PRIVACY ACT 1988 • PRIVACY ACT AMENDMENTS-PRIVATE SECTOR-ACT 2000

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals. If necessary, we will discuss this with youI understand the reasons why my information must be collected.

- I have read the information above and understand the reasons why my information must be collected.
- I am aware that this practice has a privacy policy on handling patient information.
- I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.
- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
- I understand that if I request access to information about me, the practice will be entitled to charge me fees to cover
    - time spent by administrative staff to provide access (at the employee's hourly rate of pay)
    - time spent by a medical practitioner to provide access (at the practitioner's ordinary sessional rate)
    - photocopying and other disbursements at cost
- I understand that if my information is to be used for any purpose other than the above, my consent will be sought.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice. ☐

FINANCIAL CONSENT

- **Please be advised that at this practice it is not customary to issue accounts.** Payment is due at time of consultation.
- All overdue invoices will incur a penalty fee equivalent to 25% of the outstanding amount.

I understand that penalty fees are payable on all overdue invoices, as specified above ☐

SIGNATURE

Signed_____ **Date:** _____

Name _____