Patient Details

theentcentre

PATIENT - CHILD

__________________________ ____

First Name Surname

HOME ADDRESS:

____

Suburb ___________________________________

State ______________ **Postcode** _______________

Home Phone ________________________

Mobile _____________________________

Date of birth _________________________ **Sex of child (Select one) M F X**

Medicare No. ____ **Ref** __________

Private Health Fund ____________________________ **Membership No.** ________________________

Level of Cover (if known) ____

PARENT/CARER (Complete at least one section for account holder information)

MOTHER

Mrs/Ms/Miss/Other ___ _____________________

Title (Circle one) First Name Surname

DOB _______________________

Medicare No. __________________________
(If different from child)

Ref. No on Medicare Card ___________

Work Phone _______________________________

Mobile ___________________________________

Email ____________________________________

FATHER

Mr/Other ____ _________________________

Title First Name Surname

DOB ______________________

Medicare No. __________________________
(If different from child)

Ref. No on Medicare Card ___________

Work Phone _______________________________

Mobile __________________________________

Email ____________________________________

REFERRAL

Referring Doctor ____ **Specialist/GP (circle one)**

Suburb ____________________________________

General Practitioner (if different from above) ________________________ **GP Phone** _________________

Are there any other medical practitioners you would like to have copied on correspondence? Please list below

Name Suburb Phone

____

____

Patient Consent

theentcentre

I consent to contact via email and SMS.

Signed ______________________________ **Date:** ______________________

Parent/Carer Name (Please print) ______________________

CONSENT TO COLLECT PATIENT INFORMATION

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

This medical practice collects information 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 you

- 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, 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, the practice will be entitled to charge me fees to cover
    - time spent by staff to provide access (at the employee's hourly/sessional rate of pay)
    - 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 child's 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.

Signed ______________________________ **Date:** ______________________

Parent/Carer Name (Please print) ______________________

FINANCIAL CONSENT

- Please be advised that payment for services is due at time of consultation.
- All invoices overdue by greater than 7 days will incur a penalty fee equivalent to 25% of the outstanding amount..

I understand that I am responsible for all medical fees on behalf of my child.
I understand that penalty fees are payable on all overdue invoices. as specified above

Signed ______________________________ **Date:** ______________________

Parent/Carer Name (Please print) ______________________