Redlands
SPECIALIST CENTRE

PERSONAL DETAILS:

Mr / Mrs / Ms / Miss / Dr (please circle)

Surname: ______________________ First Name: ________________________________

Date of Birth: _____/ _______/ _________ Preferred Name: ____________________________

Address: ____

Phone: Mobile: ___________________ Home: _________________ Work: ______________

Email address: ____

Name of Referring Practitioner: ____

Address of Referring Practitioner: ____

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Name and Address of GP if not the same as referring doctor: _____________________________

____

NEXT OF KIN:

Name: ____________________________________ Relationship: ____________________

Phone: Mobile: ___________________ Home: _________________ Work: ______________

MEDICARE NUMBER:

Reference Number: ____________ (number in front of your name) Expiry Date: ______/________

Do you have Private Health Insurance?

Fund: ________________________ Membership number: __________________

Veterans' Affairs Card Number: ____________________ Gold/White/Orange (please circle)

Do You Hold a Pension or Concession card? Number __________________________ Expiry _________

For Workers Compensation or Insurance Claims please complete the section below:

Employers name and address: ____

____

Insurance Company ____

Claim Number: _______________________________ **Date of injury:** _____________________

How injury occurred: ____

Case Manager Name: _____________________ **Phone:** ____________________________

I hereby accept responsibility for payment of my account if Workover or Health Fund rejects my claim.

Signature _________________________________ **Date** ____________________________________

PRIVACY INFORMATION AND CONSENT FORM

This form explains what your rights are over the use we make of your information and how we may disclose it to other medical service providers.

The law gives you certain privacy rights in relation to information that you give to this medical practice. We need your consent to collect personal information about you. The fact that you have come here implies that you consent to us knowing about your health situation either for a particular event or generally. The information we may ask you to give us is deeply personal. But not having it will restrict our capacity to provide you with the standard of medical care that you expect.

Please carefully read the following information about privacy issues then sign this form where indicated below. It will go on your file and you may examine it or change it at any time.

The main reason we collect information from you is so we can assess, diagnose and treat your illnesses properly and be proactive in your health care. We will also use the information you provide in the following ways:

- Administrations of this Medical Practice.
- Billing, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including doctors and specialist outside this practice who may become involved in treating you. 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.
- Disclosure to others for medical defence purposes if necessary.
- Disclosure to other doctors in the practice, locums and Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.

PATIENT'S ACKNOWLEDGEMENT

I have read this form and understand why collecting information about me is necessary. 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. I also understand that failure to provide this medical practice with all the information it needs may restrict the practice's ability to provide the quality of health care and treatment I want. I am aware that I have the 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 my information is to be used for any other purpose other than set above, my further consent will be obtained. 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 about which I notify this practice now or at any future time. I consent for my personal medical records to be sent and received via email or facsimile to and from other medical professionals where it is deemed in the best interest of my health care. I consent for my personal medical records held by this practice to be communicated to me via email or facsimile when I request this in writing to the practice and where it is approved by my healthcare provider. I understand that though all possible measures are taken to keep my personal medical information secure, there is a level of risk associated with transferring records via the email and facsimile methods of communication. I acknowledge that I have read this form before signing it and that a member of the staff of this practice has at my request clarified any aspects of it that I did not at first understand.

Signed: ______________________ Print Name: ______________________

Date: ______________________