SERVICED MEDICAL SUITES

PATIENT DETAILS FORM

Title: Miss ☐ Ms ☐ Mrs ☐ Mr ☐ Dr ☐ Prof. ☐ Other:

First Name:______________________ Surname:_____________________________________

Postal Address:____

Suburb:____________________ Post Code:____________Date of Birth: _________________

Phone: Home:________________ Work:___________________ Mobile:____________________

Email: ____

Medicare Card Number: __ __ __ __ __ __ __ __ __ __ Reference # (next to your name): __

Card Expiry Date: __ __ / __ __ (mm/yy)

Referring Doctor:______________________ Usual GP (if different):______________________

Where did you hear about Dr Coll?

☐ GP ☐ Internet ☐ I'm a previous patient / from a previous patient ☐ Other:_______

Patient height: ______________________ Patient weight: ______________________

DVA or WorkCover details:

DVA card no: ________________ Expiry: _ _ / _ _ (mm/yy) DVA Card Colour:

Work Cover No:_____________________ Case Worker and Phone:_____________________

Parent/Guardian Details if Under 18:

(Please note that any parent not listed will not be able to act on the patient's behalf)

Parent 1

First Name:_________________ Surname:____________________ Date of Birth: ___/___/___

Phone: ______________________ Medicare Card Number: __ __ __ __ __ __ __ __ __ __

Medicare Reference # (next to your name): ___ Card Expiry Date: __ __ / __ __ (mm/yy)

Parent 2

First Name:_________________ Surname:____________________ Date of Birth: ___/___/___

Phone: ______________________ Medicare Card Number: __ __ __ __ __ __ __ __ __ __

Medicare Reference # (next to your name): ___ Card Expiry Date: __ __ / __ __ (mm/yy)

Signed: ________________________________

Dated: _________________________________

Completed by: __________________________

Approved Secondary Contact

Please note: You are not required to provide a secondary contact person/s if you do not wish to, but please be aware we will not provide any patient information to persons not nominated above.

Contact Person 1:

Name:________________________________ Contact Number: ________________

Email: ________________________________ DOB: ______________

Contact person 2:

Name:________________________________ Contact Number: ________________

Email: ________________________________ DOB: ______________

I authorise the above person/s to act as an authorised representative on my behalf and to:

- Seek and exchange personal information about me and my treatment with the practice
- Attend consultations in my presence with the practice
- Act on my behalf until this authority is revoked

I acknowledge that this authority will remain in force until the current period of treatment is finalised, it is revoked by myself or by my authorised representative/s, or when I appoint a subsequent person to act on my behalf after this date of authority. I understand that only the above representative can contact the practice on my behalf and requests from third parties not nominated above will be declined.

Signature:

Signed:____________________________ Dated: ________________

Completed by: ________________________

OTHER PRACTICE INFORMATION

Referrals

Over the course of your treatment, it is your responsibility to ensure that your referral is in-date to be eligible for any relevant medicare or DVA rebates. Please ask Reception when booking your appointment if you are unsure.

SERVICED MEDICAL SUITES

Ultrasounds

Dr Coll may use her Ultrasound machine during your consult to better diagnose your condition or track the progress of your injury. These are invoiced at $50 per scan; please let the Doctor know if you do not wish to have an ultrasound.

Reports / Paperwork

If you require the Doctor to complete any forms or paperwork for you, for example Super Release Forms, ADF Reports etc, please advise Reception so they can let you know of the costs associated with them. The Doctor is happy to complete what is needed.

I have read, understood and accept the above information:

Signed:________________________________ Dated: _________________

Completed by: _________________________

PRIVACY INFORMATION AND CONSENT

The Privacy Act 2000 gives you certain privacy rights in relation to the information you give this medical practice. We require your consent to collect personal information. This form explains what your rights are over the use we make of the information and how we disclose it to other medical service providers.

This form will go on your file and you may examine or change it at any time.

This medical practice collects information for the primary purpose of providing quality health care. We require your personal details and medical history to properly assess, diagnose and treat your medical conditions. The information will also be used in the following ways:

1. Administration of this medical practice.
2. Billing, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved with your health care, including treating providers such as your usual GP or Physio. This may also involve referral to other specialists, anaesthetists and pathologists, including Locums when attached to this practice for the purpose continuing patient care.
4. Disclosure to other for medical defence purposes if necessary.
5. Disclosure to other Doctors in a de-identified form for specific or educational purposes. This includes photographic material and test results.
6. Disclosure for research and quality assurance activities to improve individual and community health care and practice management.
7. Disclosure to WorkCover and Insurance companies where required by them.

PATIENT CONSENT

I have read this form and understand why collecting information about me is necessary. I am also aware this practice has privacy policy on handling patient information, which is available onsite and online at dr-sarah.com.

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 I have the right to access the information collected about me, except in certain circumstances where access may be legitimately withheld, I understand I will be given an explanation in these circumstances.

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 in the future. I acknowledge I have read this form prior to signing and that a staff member has at my request clarified any aspect I did not understand.

Signed: ______________________________

Dated: ______________________________

Completed by: ________________________