NEWSTEAD MEDICAL - NEW PATIENT FORM

PLEASE NOTE – THIS PRACTICE IS NOT A BULK BILLING PRACTICE

PATIENT DETAILS

Title: Dr / Mr / Mrs / Ms / Miss / Master (please circle one)

First Name..Middle Name..........................Surname...
Date of Birth ....
Gender: .... Do you identify as: ☐ Aboriginal
☐ Torres Strait Islander
Ethnicity:.. ☐ Aboriginal and Torres Strait Islander
☐ Neither Aboriginal or Torres Strait Islander

Medicare No: ☐☐☐☐ ☐☐☐☐☐ ☐ Position on card (ie 1): ☐ Expiry Date: ☐☐/20☐☐

Health Care Card No. (CRN):..Expiry Date:..............................

Pension Card No:..Expiry Date:..............................

Veteran Affairs No...

Payer of Accounts: ....Self: Yes / No (please circle one) ☐ Workers Compensation

OR ....Other: Name: ....
Address:..(if different to yours)

Privately insured – Yes / No

PATIENT CONTACT DETAILS

Address..Suburb...Post Code.....................

Postal Address: As above / or: ....

Telephone (Home) ....(Work) ....(Mobile) ....

Email address ....Preferred contact method: E-mail ☐ SMS ☐ Phone call ☐

Please tick if you would like to receive SMS reminders about appointments ☐

NEXT OF KIN DETAILS

Name ....

Address..Phone ....

....Mobile..

Relationship of this person to you... DOB: ....

ADDITIONAL EMERGENCY CONTACT DETAILS

Name ....

Address ....Phone ....

.... Mobile..

Relationship of this person to you... DOB: ....

OTHER INFORMATION

Marital Status................................ Occupation..................................... Country of Birth.......................................

Spoken Language........................... Year of arrival in Aus........................ Interpreter required Yes ☐ No ☐

SAFETY NET PROGRAM

All patients (including immediate family) registered for our Safety Net Program who attend the surgery more than 10 times during the year will be charged at a reduced fee. Please ask at Reception for more details.

Terms:

1. **I accept that payment in full is required at the time of consultation**
2. **I accept that I will be charged a fee if I do not attend my appointment or if I fail to give a minimum of 2 hours notice for cancellation of my appointment.**
3. **I will accept full liability for workers compensation claims which are rejected.**
4. **I accept that accounts not paid will be referred to a collection agency. All legal costs, commission and other associated costs will be added to the amount due**
5. **I accept that if accounts remain unpaid no further medical service will be provided**

Signed by ....Date............................
(by signing this form you accept the above terms)

PRIVACY CONSENT FORM

Compliance with Federal privacy laws, by all doctors practising medicine in the private sector, is required from 21 December 2001.

As a result of the privacy laws, we are required to obtain written consent to collect any personal health information about you. This information is what we have always needed and used for your care. Please read this information carefully and sign where indicated below.

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 a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We, therefore, require your consent to the handling of your personal health information including:

- Keep a record of each consultation, which will be maintained and referred to by your doctor, in the management of any health problem which may arise.
- Disclosure to others involved in your health care, including treating doctors, specialists or allied health professionals outside this medical practice.
- The ordering of medical tests at pathology and x-ray and in the completion of any insurance reports, medical reports and any documentation that your doctor feels is relevant to your health care.
- Specialist reports, medical tests, x-ray or pathology results being returned to us following referral.
- Disclosure to other doctors, locums, registrars, medical students associated with this practice, solely for the purpose of patient care and teaching.
- The participation in recall systems such as, Health Assessments, Diabetic Reviews, Asthma 3+ visit plans, pap smears, and any health checks deemed appropriate by the doctor and in consultation with you. The practice will then contact you by letter or phone to remind you of health issues, which have become due.
- Administrative purposes in running our practice, including billing and compliance with Medicare and Health Insurance Commission requirements
- Quality Assurance activities such as accreditation.
- Quality improvement or clinical audit activities for the purpose of seeking to improve the delivery of a particular treatment and to promote health.
- For legal related disclosure as required by a court of law (eg subpoena, court order, etc)
- For research purposes (de-identified – meaning you are not able to be identified from the information given)

If you have any concerns or wish to restrict access to your personal health information, please discuss these with your doctor. This practice adheres to the RACGP Handbook for the Management of Health Information in Private Medical Practice and has a written policy, which is available to all patients for inspection.

I have read the information above and understand the reasons why my information must be collected. I am also 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 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 my information is to be used for any other purpose other than set out above, my further consent will be obtained.

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

I consent to being on the practice's recall system as detailed above.

Signed: ……………………………………………… Date: ………………… Printed Full Name: …………………………………

If signing on behalf of a patient, please print patient's full name ……………………………………………