THE SURGERY; ALBANY

NEW PATIENT FORM

PATIENT: (Mr Mrs Miss Ms) Surname/Family Name……

Given Names ……D.O.B……/……/……

Address……Post Code……

Postal Address……E-mail……

Phone Home (……)……Business (……)……Mobile……

Country/State of Birth……Mother's Maiden Name……

If born in Western Australia which hospital……

Occupation……Employer…… Ph……

Are you of Aboriginal or Torres Strait Islander origin?

□ No

□ Yes Aboriginal □ Yes Torres Strait Islander □ Other Cultural Background. Please specify……

Do you need an interpreter? YES □ NO □

CONTACT DETAILS

Next of kin ……Emergency Contact……

Address…… .. Address……

Phone…… Phone……

PERSON PAYING ACCOUNT

Complete this section if <u>Patient</u> is not The Account Payer.

Surname……Given Names……

Address……Post Code……

Telephone Home (……)……Business (……)……

Date of Birth ……/……/…… Relationship to Patient……

Employer ……Employers address……Ph……

HEALTH FUND

Medicare Number: ……Position on card…… Expiry Date ……/……

Private Fund: Name……Number……Table……

Pension / Health Care Card……Expiry Date ……/……/……

TERMS

1. **Payment in full is expected on the day of attendance.**
2. **The payer will accept full liability for Workcover and Insurance Claims that are rejected.**
3. **Accounts overdue by more than 30 Days will be subject to interest until payment is made.**
4. **Dishonoured cheques: Fees incurred will be added to the account.**
5. **Your de-identified clinical information may be used for the purposes of clinical audit, review and improvement activities.**

Signed By……on day of 20 .

In the presence of ……

By signing this form you confirm the information is accurate and accept the above terms. To be signed by the patient and/or the person responsible for payment. (6/12) ***<u>Copy offered</u>*** ***<u>Copy taken</u>*** …/2

PRIVACY ACT: **Patient consent to collect & disclose personal information.**

Collection:
We will collect information that is necessary to properly treat you. Information may include:

- Full medical history
- Family medical history/genetic information
- Ethnicity
- Contact details
- Medicare/DVA/private health fund details
- Vaccination records ie Australian Childhood Immunisation Register (ACIR)
- Billing/account details

The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources, for example:

- Other medical practitioners, such as former GP's and Specialists
- Other health care providers, such as Physiotherapists, Occupational therapists, Pharmacists,
- Hospitals and Day Surgery Units, Dentists, Nurses, Psychologists,
- National/State/territory reminder systems & registers

In emergency situations we may need to collect personal information from relatives or other sources.

Use & Disclosure:
With your consent, the practice staff will use and disclose your information for purposes such as:

- Account keeping and billing purposes.
- Referral to another medical practitioner or health care provider
- Sending specimens, such as blood samples or pap smears, for analysis
- Quality assurance, practice accreditation and complaint handling
- To meet our obligations to our medical defence organisations or insurers
- To prevent or lessen a serious threat to an individual's life, health or safety
- Where legally require to do so, such as producing medical records to court, mandatory reporting of child abuse or the notification of certain communicable diseases
- To meet our obligations to Companies in pre-employment and other medicals

Access:
You are entitled to access your own health records at any time convenient to you and the practice, where possible requests should be made in writing.

Access can be denied where:

- To provide access would create a serious threat to life or health
- There is a legal impediment to access
- The access would unreasonably impact on the privacy or another
- The information relates to anticipated or actual legal proceedings.

We may impose a fee for photocopying & administration costs involved in processing your request . Where you dispute the accuracy of the information we have recorded you are entitled to advise us of this and we will record your corrections on your electronic file, However, we will not erase the original record.

Consent:

1. I give my consent for The Surgery to collect , use and disclose of my personal information as outlined above.

Patient Name: _____ **Signature:**_____

Date: _____/_____/_____