NEW PATIENT REGISTRATION

Please **COMPLETE ALL SECTIONS**
before returning this form to reception

Title:	**Surname** *(as recorded on Medicare Card):*	**Given Name(s)** *(as recorded on Medicare Card):*
Preferred Name:	**Date of Birth:** DD / MM / YYYY	**Gender:** M F OTHER
Residential Address:		
Suburb:		**Postcode:**
Postal Address *(if different to above):*		
Telephone #:	**Mobile #:**	
	I consent to receive appointment bookings, reminders, & general information via SMS **Y / N**	
Email:		
	(Please note: all receipts and patient correspondence will be sent to this email address)	

Medicare Card #: _ _ _ _ _ _ _ _ _ _	**Your Ref #** *(to the left of your name)* 1 2 3 4 5 6	**Expiry:** MM / YYYY

CONCESSION CARD	**BLUE:** CRN _ _ _ - _ _ _ - _ _ _ _	**Exp:**
	DVA GOLD/WHITE: CARD NUMBER	**Exp:**

PRIVATE HEALTH	**FUND NAME:**	**MEMBERSHIP #:**	
	HOSPITAL COVER: YES / NO	**Policy held for more than 12 months?** YES / NO	**Known excess?** $

Usual GP:	**Practice:**
Optometrist:	
Usual Pharmacy/Chemist:	

Is this treatment related to a WORKERS COMPENSATION or MOTOR VEHICLE Claim? YES / NO
(if yes, please notify reception)

Emergency Contact/Next of Kin **Name:**

Contact Number: **Relationship:**

Do you consent to us giving this person your appt information and requesting other medical info on your behalf? Y / N

Payer/Account Holder *(if patient is under 16):*	**Date of Birth:** DD / MM / YYYY	
Medicare Card #: _ _ _ _ _ _ _ _ _ _	**Ref #** *(to the left of your name)* 1 2 3 4 5 6	**Expiry:** MM / YYYY

PLEASE READ, SIGN, AND DATE THE PRIVACY & CONSENT ON THE REVERSE SIDE OF THIS FORM BEFORE RETURNING TO RECEPTION

PRIVACY POLICY

This clinic collects information from you for the primary purpose of providing quality health care. Federal Privacy Law requires your consent to this. We need your personal details and full medical history (which may include photographic records) so that we may properly assess, diagnose, treat and manage your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice, which may include confirmation of your appointment via SMS or email
- Billing purposes - including, but not limited to, compliance with Medicare and the Health Insurance Commission requirements.
- 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 of results returned to us following the referrals.
- Disclosure to other doctors in the practice, locums and trainees attached to the practice for the purpose of patient care and teaching.
- Emergency situations whereby medical officers/hospitals may require access to patient notes for treatment purposes.

CONSENT

I have read the above information and understand the reasons why my information must be collected

- I understand that I am not obliged to provide any information requested, but that 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 about me, except in some circumstances where access might legitimately be withheld and that an explanation will be given to me in this circumstance. I understand that a charge may be imposed to provide copies of my medical records on request.
- I understand that if my information is to be used for any purpose other than the above, this clinic will seek my consent prior.
- I consent to this clinic using my personal information in the ways outlined above.
- I consent to the use of AI to assist my specialist document my consultation.
- I also understand that if there is a need for a procedure or treatment, there will be additional fee for these.
- I understand for security purposes the common area at this clinic is under video surveillance.
- I understand that my results will be communicated from the treating Doctor via primary SMS/ email contact provided or via my referring doctor.
- I understand I am responsible to call for my results if I have not had my results confirmed within in reasonable time frame.
- I understand that consultations are not routinely bulk billed &/or not payable by private health insurance, and consult fees are payable on the day of consultation.
- Workers Compensation Patients: I understand if I do not provide appropriate insurance information and policy number, I am responsible for payment.
- I understand most services attract a Medicare rebate, and my invoice will be sent electronically at the completion of my appointment. The rebate is deposited to your nominated bank account (details with Medicare) within 24-48 hours.
- I understand it is my responsibility to ensure I have a current valid referral, however GSSC will remind me when appointments are made. It is noted referrals from a General Practitioner or Optometrist are valid for a 12 month period, and referrals from Hospital doctors or specialists are only valid for 3 months. Each referral is condition specific.

Name: _____

Signature: _____ Date: _____