Healthology
MEDICAL CENTRE | RISDON

32 Sugarloaf Rd, Risdon Vale TAS 7016
P. 6146 3900 F. 9966 9978
E. risdon@healthologymedical.com.au
healthologyrisdon.com.au

Please note that Healthology Medical Centre Risdon is a private billing practice and fees are payable at the end of the consultation. We bulk bill children under the age of 16 and patients 70 years old and over.

Patient Information

Title:	Given Names:	Surname:	
Preferred Name:	Date of Birth: DD/MM/YYYY	Gender:	
Marital Status:	Are you of Aboriginal or Torres Strait Islander descent? Yes – Aboriginal Yes – Torres Strait Islander No		
Medicare Number:	Medicare Ref Number *Number next to your name	Medicare Expiry Date MM/YYYY	
Health Care Card /Pension Card / DVA Card (PLEASE CIRCLE) #		DVA Card Type:	Card Expiry Date: DD/MM/YYYY
Residential Street Address:			
Suburb:		Postcode:	State:
Postal Address: (if different from above)			
Home Phone:	Work Phone:	Mobile Phone:	
Email Address:			
Occupation:		Employer:	
Country of Birth:	Main Language Spoken	Do you require an Interpreter? Yes No	

Next of Kin Contact Information

Full Name:	Relationship to you:	Home Phone:
Address:		Mobile Phone:

Emergency Contact Information

Full Name:	Relationship to you:	Home Phone:
Address:		Mobile Phone:

****please complete both front and back of the new patient registration form****

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 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 associated costs will be added to the account.
5. I accept that if an account remains unpaid, no further medical services will be provided.

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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. The 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 information including:

- Keep a record of each consultation, which will be maintained and referred to by your doctor, in the management of any health problems 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-rays, or pathology results being returned to us following referral.
- Disclosure to the 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 Annual Health Assessments, Diabetic Reviews, Asthma Reviews, Pap Smears, and any health checks deemed appropriate by the Doctor and in consultation with you. The practice will contact you via SMS, phone, or letter to remind you of recalls that have become due.
- Administrative purposes in running our practice, including billing and compliance with Medicare 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, ect…).
- For research purposes (de-identified – meaning you are not able to be identified from the information given).

If you have any concern 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 upon request.

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 information requested of me but that my failure to do so might compromise the quality of healthcare and treatment given to me.

I am aware of my right to access the information collected about me, except in 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 recall system as detailed above.

Signed: ________________________ Printed Full Name: ____________________________ Date: ____/____/____