PERTH WEIGHT LOSS AND SURGERY

Patient Registration Form

PERSONAL DETAILS

Title: …… Surname: ……Date of Birth: ……. /……. /……..

Given Names: ..... Middle Name: ……

Address: ..... ……..

Phone (H): …… Work: …….. Mobile: ……..

Email: ……..

EMERGENCY CONTACT DETAILS

Next of Kin: …….. Phone: …… Relationship: ……

REFERRAL DETAILS

Referring Doctor: .....

Family Doctor (if different to above): .....

Address: .....

CARDS / CONCESSIONS

Medicare Number: …….. Ref #: ..... Expiry: ……. / ……

Pension / Concession Number: …… Expiry: …… / ……

Veteran's Affairs Number: ..... Card Type: .....

PERTH WEIGHT LOSS AND SURGERY

HEALTH INSURANCE DETAILS

Do you have Private Health Insurance? Yes / No

Fund Name: …… Membership No: ……

WEIGHT LOSS PATIENTS ONLY

Does your Private Health Insurance policy include weight loss surgery? Yes / No / Not applicable

Do you wish to apply for early release of superannuation? Yes / No

How did you hear about us? Please circle.

Facebook Internet Doctor Friend/Relative

I agree and acknowledge that I am responsible for payment of medical accounts. I understand that I will be responsible for payment of debt collection fees applied to overdue accounts. I understand that a cancellation fee of $25 may apply for less than 24 hours' notice to cancel an appointment or for failure to attend an appointment.

Signature: _____ Date: _____

PRIVACY ACT 1988

PATIENT CONSENT TO COLLECT AND DISCLOSE INFORMATION

We require your consent to collect, use and disclose personal information about you. 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, to properly advise and treat you. Such information may include

- Full medical history
- Family medical history
- Ethnicity
- Personal contact and health fund details
- Genetic information

Both our practice staff and medical practitioners may participate in the collect of this information.
This information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources such as other doctors, other health providers or hospitals.

With your consent, we may use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Account keeping and billing purposes

- Disclosure to others involved in your health care including treating doctors and specialist outside this medical practice, including other health care providers and insurance/health fund companies. This may occur through referral to other doctors or for medical tests, and in the reports or results returned to us following such referrals
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement
- Where legally required, such as providing records to court, mandatory reporting or child abuse or the notification of certain communicable diseases

You are entitled to access your own health records at any time convenient to both yourself and the practice except in some circumstances where access might legitimately be withheld or where your request is frivolous. A charge may be imposed for processing your request. Where you disagree with the accuracy of the information recorded, please discuss this with your doctor as you are entitled to have your corrections included in your file.

CONSENT:
I have read the information above and I provide my consent for Midland Surgical Services and associated practice staff to collect, use and disclose my personal information as outlined above.

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 the health care and treatment given to me.

I understand that I am entitled to access my own health care records except where access might be legitimately withheld. I understand that I will be given an explanation in these circumstances.

I understand that I may withdraw my consent as to use and disclosure of my personal information (except where legal obligations must be met).

SIGNED (Patient): _____ **DATE:** _____

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INFORMED FINANCIAL CONSENT
PRIVATE OUTPATIENT APPOINTMENT

☐ I agree to be treated as a private patient at Midland Surgical Service located at St John of God Private Hospital Midland and I understand that the full consultation fee will be payable at the time of my consultation.

☐ I agree that if my workers compensation or motor vehicle accident claim is denied, I will be liable for all costs incurred.

Please note that if pathology or radiology is required, there may be further out of pocket expenses as determined by the individual providers of service.

Patient name: Date of birth:

Signature: _____ Date: _____