NEW PATIENT REGISTRATION FORM

Title ☐Mr ☐Mrs ☐Ms ☐Miss Given Name ....

Surname ....Preferred Name: ....

Address ....

Suburb .... Postcode ....

Date of Birth .... / .... / .... Age .... Gender ☐M ☐F

Telephone Home .... Work .... Mobile ....

Email ....Occupation ....

Medicare Card Number .... Ref No. (Number next to your name) ....

Hospital Insurance Fund .... Member number ....

Veterans Affairs Care Card Number ....Gold Card ☐Yes ☐No

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NEXT OF KIN:

Next of Kin .... Relationship ....

Home Phone .... Mobile ....

REFERRING DOCTOR:

Full Name .... Clinic Name ....

Address ....

FAMILY DOCTOR: (if not referring Doctor)

Full Name .... Clinic Name ....

Address ....

PHYSIOTHERAPIST:

Full Name .... Clinic Name ....

Address ....

Other Health Professionals involved in your care

1 Full Name .... Clinic Name ....

Address ....

2 Full Name .... Clinic Name ....

Address ....

Please Turn Over

THIS SECTION IS FOR 'WORKCOVER/TAC' CLAIMS ONLY

Date of injury .... Claim Number ....

Name of Insurance Company ....

Insurance Company Address ....

Case Manager's Name .... Phone Number ....

Employers Name .... Phone Number ....

Employers Address ....

Where did you hear us?

- ☐ Referring *Doctor*
- ☐ *Physiotherapist*
- ☐ *Sports Physician*
- ☐ *Family Member / Friend*
- ☐ *Internet*
- ☐ *Other (please specify)* ....

FEES PAYABLE A referral (within 12 months) from your Local Doctor is required for your Medicare rebate.

INITIAL CONSULTATION $ 205.00
REVIEW $ 95.00

BILLING AND PRIVACY POLICY

A. I authorise the medical practice to electronically transmit my claim for Medicare benefits to the Australian Government Department for Human Services on my behalf

B. I understand this practice handles personal information in accordance with the National Privacy Principles enshrined in the Privacy Act 1988 (Commonwealth), and as outlined in the Privacy Statement. I consent to the handling of my information by this practice for the purpose of providing quality health care, associated administrative billing purposes and for other treating allied health professionals. I also give permission for medical information to be obtained from any other source in order to assist with my treatment

C. I understand my health information will be used for "secondary purposes" such as auditing, monitoring surgical results and clinical research. Record keeping may also include x-rays and images/photographs. I understand the privacy of individuals is strictly maintained when reporting results of audits or research to the profession. I also consent to information, x-rays and images/photographs being used for the secondary purposes of audit and research

I have read, understood and consent to the above Billing and Privacy Policy

Signature .... Date ....