

***PLEASE RETURN THIS FORM TO RECEPTION WITH YOUR MEDICARE OR DVA AND CONCESSION CARDS (if applicable)**

MACKIE ROAD CLINIC - PATIENT REGISTRATION

Surname	Title:		
Given Names	Preferred Name:		
Street Postal			
Suburb	Postcode:		
Date of Birth			
Home Phone	Work Phone:		
Mobile Phone			
Medicare Number	Ref No:	Exp:	
DVA Number		Exp:	
Pension/HCC Number	Type:	Exp:	
Occupation			
To assist with Health Initiatives – Are you of Aboriginal or Torres Strait Islander origin <input type="checkbox"/> Yes <input type="checkbox"/> No			
Next of Kin (Name, Phone No & relationship)			
Person responsible for account (please give details below)			
Name			
Address (if different to above)			
Medicare No.		Ref No.	Date of Birth :
Reminder Systems: Our practice provides patients with preventive care and early case detection reminders eg. Immunisations, annual health checks, skin checks and pap smears. Do you wish to have any relevant health reminders sent to you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you wish to receive an SMS as a reminder for appointments, recalls, and to request a call back? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How did you find out about us? <input type="checkbox"/> Family/Friends <input type="checkbox"/> On Line <input type="checkbox"/> Advertising <input type="checkbox"/> Health Professionals <input type="checkbox"/> Other (please specify).....			

PATIENT CONSENT FORM

Please read our policies carefully and sign where indicated on the second page.

PRIVACY POLICY

In accordance with the National Privacy Principles, we are required to record your consent to enable us to collect and handle personal information about you.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with accurate and up to date personal details and a full medical history so that we may safely and properly manage your health care needs.

We may use the information you provide to us in the following ways:

- Administrative purposes in running our practice
- Billing purposes in compliance with Medicare and HIC requirements
- Disclosure to others involved in your healthcare, including specialists and other health care providers outside this medical practice. This may be in the form of referral letters and/or by collecting deidentified statistical information for clinical audits used for improved health care.

In collection, storage, release and transfer of your personal information, this practice is bound by the Commonwealth Privacy Act and Australian Privacy Principles. And also complies with the Health Privacy Principles.

CANCELLATION POLICY

We understand that something may come up that may prevent you from attending the appointment.

If you cannot keep your appointment or you need to reschedule it, you can do it over the phone or in person.

We know your time is valuable, the same as our doctors' time. Thus we require at least 12 hours' notice if you cannot keep your appointment so that we can give your appointment time to another patient who can attend.

A fee of \$35 applies to non-attendance or late cancellations (less than 12 hours prior to your appointment). The fee is not rebatable through Medicare. If there are any circumstances beyond your control which prevent you from cancelling your appointment with sufficient notice you should let us know as soon as possible.

SMS REMINDERS

We are currently offering text messaging service (SMS) as a reminder service for appointments and recalls, and to request a call back. Patient consent is obtained and recorded before health information is communicated by SMS. It is the patient's responsibility to inform us promptly about changes to their contact details particularly mobile phone number for SMS purposes. By consenting to the text messaging service patient agrees that Mackie Rd Clinic will always perform due diligence in protecting patient information but has no responsibility for the messages received and/or read by the wrong recipient.

Patient acknowledges and agrees that the receipt of sms messages is not guaranteed, may sometimes be delayed and may depend on various factors. Patient acknowledges and agrees that they are responsible for their appointment time and will be charged a cancellation fee for non- attendance whether they have or have not received the SMS reminder even if explicitly requested.

CCTV

CCTV is in operation for staff and patients' personal safety and security. Only public areas are covered by our video surveillance system.

PATIENT DECLARATION

I have read and understood the information above.

I understand that I am not obliged to provide any information requested of me, but that failure to do so might compromise the quality of health care given to me.

I am aware of my right to access the information collected about me, except in legitimate circumstances that will be explained to me should they arise.

I understand that if my information is to be used for any other purpose other than that set out above, my further consent will be obtained.

Any limitations that I place on the handling of my personal information, I undertake to set out in writing.

I undertake to promptly notify the practice of changes to my personal details including contact phone number.

I undertake to notify the practice if I cannot keep my appointment.

Signature of Patient or Guardian:.....

Name Printed in full:.....**Date:**.....