PATIENT INFORMATION SHEET
Mr Derek Carr
Private & Confidential

Mr/Dr/Mrs/Miss/Ms/Mst…… D.O.B……
(Surname) **(Given Name)**

Address……. Post code…….

Phone (H)…….. (W)……... (M)…….

Email address ……

Occupation……..

Next of Kin…….Relationship…….
Contact number……
Referring Doctor's Name…….… GP's Name……..

GP's Address……

Health Fund…….. Membership number……..

Medicare No……. Card Ref No……. Expiry……
(Left hand side of name)

Dept of Veteran Affairs No……

Is this a TAC/Workcover claim? YES/NO Claim no……

If Workcover, name of the insurance company or employer…….

Workcover or Employer's address…….

General Health

Allergies?.....

Significant Medical Problems? *(If not listed on referral)* .....

Medications? *(If not listed on referral)* .....

…….
BILLING TERMS:
Please note that this practice does not bulk bill Medicare directly for your accounts. You will receive a personal account for professional services that Mr. Carr has provided. Accounts are itemized at a rate outlined by the AMA and are above the standard Medicare rebate. You will be given an invoice after your consultation, at which time settlement would be appreciated. Payment can be made by credit card, EFTPOS, cash or cheque. For any further information about the billing policy, management of overdue accounts and Gap Cover schemes for inpatient services, please ask our staff.
PRIVACY POLICY:
I have read and understand the requirements outlined in the privacy policy of this medical practice, and give my consent for my information to be used in this manner.

Patient Signature…… Date…….

PRIVACY POLICY: MR DEREK CARR

We require your consent to collect personal information about you. Please read this information carefully.

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. This means we will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.

2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.

3. 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 or results returned to us following the referrals.

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 obligated 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 am aware of my right to access the information collected about me, except in some 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 purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.