HOLLYWOOD GYNAECOLOGY

Patient Details

PREFERRED GYNAECOLOGIST:

Dr Krish Karthigasu

PATIENT DETAILS

◯ Mrs ◯ Miss ◯ Ms ◯ Dr

Given names: **Surname:**

Date of birth:

Address: **Postcode:**

Home phone: **Work:** **Mobile:**

Email:

Occupation:

Emergency contact: **Phone:**

HEALTH CARE

Medicare number: **Card reference:** **Expiry:** / /

Health fund: **Member No:**

Have you been with your health fund for more than 12 months? ◯ YES ◯ NO

Give details of person who will be responsible for this account if different from above:

Name: Relationship to patient:

Phone:

GP details (if different to referring doctor) Name:

Address: Postcode:

HISTORY

Allergies:

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Patient Information

PATIENT INFORMATION

FEES: This is a PRIVATE billing practice and the fees are charged based on AMA recommendations.

Payment is required at the end of each consultation. These accounts are claimable from MEDICARE. These fees are subject to increase every November.

Failure to attended an appointment without having cancelled with the rooms at least 24 hours prior may attract a $50 fee which is not claimable from MEDICARE.

PATHOLOGY

If you have a cervical screening test, biopsy or other type of pathology carried out at the time of your appointment you will receive a separate bill in the mail from the PATH WEST DEPARTMENT. They are totally separate accounts and should be paid separately.

REFERRALS

Your referral from your general practitioner to this centre is usually valid for 12 months. If you are referred by a specialist, this referral is only valid for 3 months. Medicare requires you to have a valid referral to be to claim your full refund. It is your responsibility to ensure you have a valid referral.

If you have read and understand this patient information please sign.

Signature: **Date:**

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Patient Consent

PATIENT CONSENT

PRIVACY ACT 1988: TO COLLECT & DISCLOSE INFORMATION

The Privacy Act 1988 requires medical practitioners to obtain consent from their patients to collect, use and disclose that Patient's personal information.

Collection
This means we will collect information that is necessary to properly advise and treat you. Such necessary information may include:

- Full medical history
- Family medical history
- Ethnicity
- Contact details
- Medicare/private health fund details
- Genetic information, and
- Billing/account details

The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources, for example:

- Other medical practitioners, such as former GPS and Specialists
- Hospitals and Day Surgery Units, and
- Other health care providers such as physiotherapists, occupational therapists, psychologists, pharmacists, dentists, nurses.

Both our practice staff and the medical practitioners may participate in the collection of the information.

In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent.

Use and Disclose
With your consent, the practice staff will use and disclose your information for purposes such as:

- Account keeping and billing purposes
- Referral to another medical practitioner or health care provider
- Sending of specimens, such as blood samples or cervical screening test for analysis
- Referral to a hospital for treatment and/or advice
- Advice on treatment options
- The management of the practice
- Quality assurance, practice accreditation and complaint handling
- To meet our obligation of notification to our medical defence organisation or insurers
- To prevent or lessen a serious threat to an individual's life, health or safety, and
- Where legally required to do so, such as producing records to court, mandatory reporting of child abuse or notification of diagnosis of certain communicable diseases.

Access
You are entitled to access your own health records at any time convenient to both yourself and the practice.

Access can be denied where:

- To provide access would create a serious threat to life or heath
- There is a legal impediment to access
- The access would unreasonably impact on the privacy of another
- Your request is frivolous
- The information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings*
- In the interest of national security.

We ask that, where possible, your request be in writing. We may impose a charge for photocopying or for staff time involved in processing your request. Where you dispute the accuracy of the information we have recorded you are entitled to correct that information. It is our practice policy that we will take all steps to record all of your corrections and place them with your file but will not erase the original record.

CONSENT

◯ **I provide my consent for my doctor to collect, use and disclose my personal information as outlined above.**

◯ **I understand that I am entitled to access my own health records except where access would be denied as outlined above.**

◯ **I understand that I may withdraw my consent to use and disclose my personal information (except when legal obligations must be met).**

Patient name: _____

Patient signature: _____