HOLLYWOOD GYNAECOLOGY

Patient Details

PREFERRED GYNAECOLOGIST:

Dr Robyn Leake ◯

Dr Jennifer Pontre ◯

PATIENT DETAILS

◯ Mrs ◯ Miss ◯ Ms ◯ Dr Personal pronouns:

Given names: Surname:

Date of birth:

Address: Postcode:

Home phone: Work: Mobile:

Email: Occupation:

Emergency contact: Phone:

Height: Weight: BMI:

Privacy password - Mother's maiden name: First pet's name:

Used to identify you when discussing private medical information by 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

Do you have hospital cover? (not ancillary cover only)? ◯ YES ◯ NO

DVA number: Card: ◯ WHITE ◯ GOLD

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

Patient history:

Medications:

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 attend an appointment without having cancelled by calling or emailing 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 test carried out at the time of your appointment you will receive a separate bill in the mail from the PATH WEST DEPARTMENT. These 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

COLLECTION OF PERSONAL INFORMATION, PRIVACY ACT 1988

We require your consent to collect 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. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and be pro-active in your health care. We will also use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- 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. If necessary, we will discuss this with you.
- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note your record accordingly.
- 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.

CONSENT

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 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 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 I request access to information about me, the practice will be entitled to charge me fees to cover:

- **time spent by administrative staff to provide access at the employee's hourly rate of pay**
- **time necessarily spent by a medical practitioner to provide access at the practitioner's ordinary sessional rate and**
- **for photocopying and other disbursements at cost.**

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 that I notify this practice of.

Signature: **Date:**