WINDMILL HILL MEDICAL

Registration form

For new patients

PATIENT INFORMATION

Mr/Mrs/Miss/Ms ..... (other)

Full name .....

Residential address ..... Postcode .....

Postal address ..... Postcode .....
(if not same as above)

Phone - Home ..... Work ..... Mobile .....

Occupation ..... Email .....

Date of birth ..... Country of birth .....

Gender ..... Relationship status .....

Do you identify as Aboriginal and/or Torres Strait Islander origin? Yes/No If YES, please specify .....

Medicare No ..... Ref No ..... (No. next to name on card) Expiry ..... /.....

Pension No ..... Expiry ..... / ..... / .....

DVA No ..... Gold card / White card ..... (Please specify)

Health Care Concession No ..... Expiry ..... / ..... /.....

Name of person responsible for payment of account .....

NEXT OF KIN

Full name ..... Relationship .....

Residential address ..... Postcode .....

Phone - Home ..... Work .....

EMERGENCY CONTACT PERSON

Full name ..... Relationship .....

Residential address ..... Postcode .....

Phone - Home ..... Work .....

THIRD PARTY CONSENT

Do you give permission for All Results (x-ray, blood tests, etc)
to be given to a nominated person on your behalf if they call? Yes/No

Full name .....

Relationship ..... Phone .....

TERMS & CONDITIONS

1. I accept that payment in full is required at the time of consultation.
2. I accept full liability for workers compensations claims if my employer is not formally registered with Windmill Hill Medical.
3. I accept that accounts not paid within 30 days will attract a late payment fee and any account not paid within 90 days will be referred to a collection agency. All legal costs, commission and other associated costs in debt recovery will be added to the amount due.
4. I accept that if an account remains unpaid, no further medical services will be provided.
5. I accept that payment of a non-attendance fee is an obligation to be a patient at this practice.

Signed ..... **Date** ..... **/**..... **/** .....

(By signing this form you accept the above terms)

CONSENT FORM FOR COLLECTION AND USE OF PERSONAL INFORMATION

This practice has produced a Privacy Policy that outlines the way we collect and use your information and how you can access that information.

This consent form covers collection and use of your information (including your Government issued Individual Health Identifier) to provide comprehensive, co-ordinated and continuing whole person medical care. As outlined in the Privacy Policy, your information may be disclosed to other health care professionals to provide this level of care. In addition there are circumstances when information has to be disclosed such as:

- Emergency situations
- Public health statutory requirements on notifiable diseases
- Medical indemnity insurance obligations
- Provision of information to Medicare or private health funds for billing and rebate purposes
- Quality assurance purposes

In order to provide high quality care to you we operate a recall and reminder system. This means that when you are due for routine preventative health measures such as Cervical screening, diabetes reviews, vaccinations, health checks etc we will contact and advise you to make an appointment. We also participate in the Government Pap Smear Register, Australian Childhood Immunisation Register and My Health Record system.

We will also contact you if you have had a pathology or x-ray test done and you have not contacted us for a result that the doctor advises needs to be followed up. **It is Practice Policy, and in your interest, that you ring for your results on the dedicated phone number for any tests you have had through this practice in the timeframe advised by your GP.**

We feel that the above measures are a fundamental part of the high quality healthcare and we strive to give to all our patients. To aid this it is essential we have your most recent contact details and that you advise the practice of any change.

Separate and specific consent is required if your information is to be used for research or statistical purposes, or if any third party eg insurance company, workers compensation, or employer requests your medical information. By signing this consent form you acknowledge that you have read the Privacy Policy and you agree to your information being collected and used as described in the Privacy Policy.

I have read and understood the Privacy Policy provided by this practice and I consent to the collection and use of my information as described in the Privacy Policy. I also agree to participate in this practice's recall and reminder systems.

Signature of patient/person responsible* ..... **Date** ..... / ..... / .....

Print full name .....

*A 'person responsible' means a person defined as a 'person responsible' under the Privacy Act 1998 including the patient's partner, family member, carer, guardian, close friend, and a person exercising power