Patient Information and Privacy Consent

Better Medical

Title	**□ Mr □ Mrs □ Ms □ Mast □ Miss □ Dr □ Prof □ Other**
Family Name	
Given Name/s	
Preferred Name	
Date of Birth	**/ / Sex □ Male □ Female □ Other**
Ethnicity	**□ Aboriginal □ Torres Strait Islander □ Aboriginal & Torres Strait Islander □ Australian □ Other (please elaborate)**
Chose/referred to Clinic because of	**□ Dr □ Family □ Friend □ Close to home/work □ Postcard in mail □ Other Health Service □ Website □ Facebook □ Other (please elaborate)**

Street Address	
Suburb & Postcode	**Postcode**
Postal Address (if different)	
Contact Details	**Home (08) Work (08)**
Mobile Phone	
Preferred contact	**□ Mobile □ Work □ Home**
Email	**Consent to SMS □ Yes □ No**
Occupation	

Medicare Number	**Ref Exp**
Pension/HCC/CW Seniors (circle)	**Exp**
DVA Details	
Payer of account (under 16 years to be linked to parent on Medicare card)	**□ Self □ Parent □ Guardian □ Other**
Parent/Guardian's full name and DOB (if patient is under 16 years)	**Family Name Given Name** **Date of Birth / /** **Medicare (if different from above)**
Next of Kin (if different to above)	**Title Given Name Family Name** **Date of Birth / /**
Address	**□ As Above OR**
Relationship	
Phone contact	**1. 2.**
Emergency Contact	**□ As Above OR Given Name Family Name**
Phone contact	**1. 2.**
My Health Record	**□ Tick box for assistance with My Health Record**

PLEASE TURN OVER TO READ AND SIGN OUR PRIVACY CONSENT FORM

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Our Practice values the privacy and security of your personal health information and uses standards-compliant secure messaging. As a patient of our medical practice, 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 medical conditions to ensure we are proactive in your health care. To enable ongoing care, and in keeping with the Privacy Act 1988 and Australian Privacy Principles, our aim is to provide you with sufficient information about how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in running our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up calls, reminder/recall notices via letter, SMS or email for treatment and preventative healthcare.
- 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.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential. Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

I have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed by Hills Medical Pty Ltd. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained

I give permission for my personal information to be collected, used and disclosed as described above including follow up phone calls and contact via SMS and email.

I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing. I understand that I can access the full Privacy Policy for further information.

I am aware that Practice Policy requires all patients to see a Doctor for test results and whilst every effort will be made to contact patients with abnormal results, it cannot be assumed that test results are normal if there is no contact from our clinic.

I agree to pay all fees associated with my care at the time of consult.

Patient name (Please print)	
Signature	
If not Patient signing – Your Name (Please Print)	
Your relationship to patient	
PRACTICE USE ONLY **Witnessed by (Staff Signature)**	