Patient Registration Form

Please use a black or red pen to complete forms and questionnaires.
You must return **ALL** forms, the referral and questionnaires (except activity diary) **before** we give you an appointment. Please return the forms by email to info@fpmx.com.au, fax to 03 97700944 or post/hand to 7/20 Clarendon Street, Frankston 3199.
Please keep the 2-day activity diary and give it to the nurse or doctor at your visit.

UR:	Date of Birth:	Date:
Title:	Surname:	
Given Names:		Preferred Name:
Address:		Postcode:
Telephone: Home:	Mobile: ☐ I authorise reminder SMS messages	
Business:	Email: ☐ I authorise reminder e-mail messages	
Next of Kin:		
Name & address of GP:		
Referring Doctor:		
Other Health Professionals:		
Medicare No:	Pension No: Disability / Old Age / other	
Expiry Date:		
HEALTH INSURANCE FUND NAME:	Health Fund Membership No: Do you have "Gap Cover": ☐ Yes ☐ No	
VETERANS' AFFAIRS: GOLD / WHITE CARD:	DVA No:	
TAC or WORKCOVER INSURER NAME:	Claim No: D.O.A:	
CLAIMS OFFICER NAME:	Direct Telephone: Direct Fax:	
EMPLOYER'S NAME:		

I authorise Frankston Pain Management to obtain copies of letters, reports and investigation results and to correspond with or discuss my treatment plan with other treating health professionals.

Our office staff can send appointment reminders by e-mail or SMS. Ticking one or both boxes is your authority to send an appointment reminder to your ☐ E-mail address and/or by ☐ SMS to your mobile.

I have read and I accept Dr …………………………… professional fees and payment arrangements as described in the brief fee schedule dated ………………..

I am aware that there may be a gap between the fees charged and my refund and that it is my responsibility to pay the gap amount. I agree to pay all doctors' fees on the day of consultation.

Signed: ________________________________ Date: ___________

Health Information Collection Consent Form

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

Your Privacy

The doctors, health professionals and other staff of Frankston Pain Management Group are all committed to respecting your confidence and preserving your privacy as required by Law. This obligation extends to other people having lawful access to your personal information.(eg external typists)

Collection, use and disclosure of your information

Information about a patient's medical, family and general health history is needed to properly assess, diagnose, treat and be proactive in your health care needs. We will be fair in the way we collect information about our patients. This information is generally collected from the patient, and otherwise with the patient's consent. However, from time to time we may receive patient information from others. When this occurs we will, wherever possible, make sure the patient knows we have received this information. Some information is used for appointment reminders/recalls and some is also provided to Medicare, private health funds, Workcover and TAC if relevant, for billing, medical rebate or debt recovery purposes.

Medical care requires full knowledge of patient health information by all members of a medical team. To ensure quality and continuity of patient care a patient's health information has to be shared with other health care providers from time to time. In emergencies, this may involve disclosure of relevant information without consent.

The doctors and health professionals in this practice are members of various medical and professional bodies including medical defence organisations. There may be occasions when disclosure of patient information is required for medical defence or quality improvement purposes.

There are also circumstances where a medical practitioner or health professional is legally bound to disclose personal information. An example of this is the mandatory reporting of communicable diseases.

Anonymous patient information may be used in funding requests, management, planning, quality improvement or evaluation of health services, whilst ensuring that all reasonable steps are taken to maintain confidentiality.

It is necessary for us to keep patients' information after their last attendance at this practice for as long as is required by law or is prudent having regard to administrative requirements.

Access

A patient has a right to access their information. They may ask to view the information or ask for a copy of a part or of the whole record. While not required to give reasons for their request, a patient may be asked to clarify the scope of the request.

There are some circumstances in which access may be denied but in such an event, the patient will be advised of the reason.

A charge may be payable where the practice incurs costs in providing access. This will depend on the nature of the access.

The material over which the doctor has copyright might be subject to conditions that prevent further copying or publication without the doctor's permission.

If a patient finds that the information held on them is not accurate or complete, the patient may have that information amended accordingly

Upon request a patient's health information held by this practice will be made available to another health service provider. This may incur a charge to cover costs.

Parents/guardians and children

The right of children to privacy of their health information, based on the professional judgment of the doctor and consistent with the law, might at times restrict access to this information by parents or guardians.

Complaints

It is important to us that your expectations about the way in which we handle your information are the same as ours.

Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your doctor.

If you still dissatisfied you can complain to the Federal Privacy Commissioner whose contact details are:
GPO Box 5218 Sydney NSW 1042; Privacy Hotline: 1300 363 992; Website: www.privacy.gov.au

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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 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 about.

Signed:... Date:......................................