Paediatrics SA

Confidential Patient Information Sheet

(Please use black pen for scanning purposes)

Patient Name:.....
First Name Surname

Date of Birth:..... Male ( ) Female ( )

Residential Address:.....

Postal Address:.....

Medicare Number:..... Number next to child's name:.....

FOR BILLING PURPOSES MEDICARE REQUIRES THE FOLLOWING INFORMATION

Mother's Name: .....DOB: .....M/C Reference No:.....

Father's Name:..... DOB:.....M/C Reference No:.....

Telephone Numbers: Home:.....Mobile:.....

Alternative Contact Telephone Number:.....

Email Address:.....

Person Responsible for Accounts (Parent's Name):.....

Name and Address of General Practitioner:.....

.....

Do you have Private Hospital Insurance? **YES/NO** If **YES**, has it been over 12 months? **YES/NO**

Private Health Insurance Fund:..... Membership No: .....
(Hospital Cover)

Please Note:

* *We ask for full payment at the end of the consultation and this can be made by cash, cheque, credit card or EFTPOS.*
* *Referring Doctors, Treating doctors and Specialists who are involved in your child's healthcare, may be contacted and disclosure of further treatment and outcomes may be forwarded. Information will be treaed in a confidential manner at all times.*

I understand and accept the above information and agree to the fees charged:

Signed:..... **Date:** .....
Parent / Guardian

Paediatrics SA

PRIVACY INFORMATION

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 and your child 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, treat and be proactive in your health care needs. This means we will 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.

I have read the information above and understand the reasons why my information must be collected.

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 or my child.

I am aware of my right to access the information collected about myself or my child 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 of which I notify this practice.

Signed:……..Date:……
Parent / Guardian