Barrack Street Practice New Patient Registration Form

This form is for patients who are intending to have Barrack Street Practice as their regular/permanent GP service.

Date: ……/……/…….

Title:	(Dr, Mr, Mrs, Ms, Miss, Master, Other)		
Surname:			
First name:		**Middle Name:**	
Preferred Name:		**Date of Birth:**	
Gender:			
To ensure that your doctor provides you with the appropriate healthcare, are you ? Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐			
Ethnicity ***(other)***			
Street Address:			
Postal Address *(if different to street address)*			

Home Ph:		**Work Ph:**		**Mobile Ph:**	
Email:					
Do You consent to receiving SMS Reminders for Appointments:	**Yes, I consent** ☐	**No, I do not consent** ☐			
Clinical Reminders:	**Yes, I consent** ☐	**No, I do not consent** ☐			
Clinical Communication (Results & Clinical messages):	**Yes, I consent** ☐	**No, I do not consent** ☐			
Health Awareness:	**Yes, I consent** ☐	**No, I do not consent** ☐			
Barrack Street Practice uses Hot Doc, the online appointment booking system which utilizes SMS reminders to patients					
Occupation:					
Medicare Number:		**Ref No:**		**Expiry Date**	
Pension Card Type:		**Card No:**		**Expiry Date**	
DVA Number		**DVA Card Colour**			
Accepted conditions if DVA White/Orange Card					
Next of Kin: *(Name, Address & Ph No)* **Relationship to Patient**					
Emergency Contact *(If different to Next of Kin)*	*(Name & telephone number of the person we can contact if needed)*				

Please read the billing information below:

Barrack Street Practice is a private billing practice. A consultation fee will apply to all new patients without exception & Bulk Billing will only be available to eligible patients following the first paid consultation. Eligible Patients who will be bulk billed are those who are under 12 years of age, are 70 years of age and over with a current health concession card or are the holders of a DVA Gold Card / White Card (specific conditions).

Please speak with the reception staff for more detailed fee information.

Please go to the next page

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, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors, Allied Health Professionals and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums and Allied Health Professionals etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

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 failure to do so may compromise the quality of health care treatment given to me.	☐
I am aware of my right to access the information collected about me, except in some circumstances where access may be legitimately withheld. 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 understand that depending on the age of my child (16 & over) and given my child's right to privacy, in the clinical judgement of the doctor treating my child I may be prevented from access to information regarding my child's healthcare	☐
I consent to the handling of my information by the practice for the purposes set out above, subject to any limitations on access or disclosure of which I notify the practice.	☐

OR

I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐

Signature: …….. **Date:** ……/……/…….

Thank you for your co-operation & please return the completed form signed to reception