Cowra Medical Associates

New Patient Registration Form

Please complete all sections. Pages 1-3.

Contact Information

Family Name			
Given Name		Date of Birth	
Title		**Gender**	☐ Male ☐ Female
Home Address			
Postal Address			
☐ Same as above			
Home Phone		**Consent to voicemail**	**No** ☐ **Yes** ☐
Mobile Phone			
Work Phone			
Email Address			
Consent to Email **outside** the practice	**Do you consent to correspondence being sent via email / password protected ZIP file (PLEASE READ PAGE 4)**		**NO** ☐ **YES** ☐
Patient Status	Do you have a MHR (My Health Record)?		Yes ☐ No ☐ Unsure ☐
	Will this be your permanent GP Practice		Yes ☐ Visitor ☐ Unsure ☐

Health Care Identifiers

Medicare Card	Ref#	10 Digit #	Exp /
DVA File Number/Card	Gold ☐ White ☐		Exp / /
Pension ☐ **Health Care** ☐ **Concession** ☐		Number	Exp / /

Personal Details (of the patient)

ATSI	☐ Non-Indigenous	☐ Aboriginal	☐ Torres Strait ☐ Aboriginal & TSI
Country of Birth		**Languages spoken**	
Marital Status:		**Occupation**	

Next of Kin / Emergency Contact

Name:_____	**Relationship to you:**_____	**Contact Phone #:**_____
Can the next of kin be contacted in the event of an emergency?	☐ **Yes**	☐ **No**

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Privacy Act – PLEASE READ CAREFULLY

Please fill this page in

- We require your consent to collect personal information in accordance with the Privacy Act 1988. Please read this information carefully and sign and complete where indicated below.
- As a result of the amendments to the Privacy Act **we are unable to give any medical information to another person unless previously nominated by you**. The preference of the practice is for this to be issued in writing.
- **It is important that if your circumstances change at any time with particular regard to the accessing of your medical information that you please attend the practice and complete another privacy act form. The Practice may at its discretion request patients to complete an updated patient data sheet and privacy act form.**

ALL PATIENT'S AGED 16 YEARS AND OVER MUST PERSONALLY ANSWER THESE QUESTIONS

Do you consent to the following? (Please tick yes or no)		
Do you consent to be contacted by telephone?	☐ Yes	☐ No
If someone else answers the phone, are we able to state where we are calling from?	☐ Yes	☐ No
Do you consent to a message being left on your voice mail/message bank?	☐ Yes	☐ No
Do you consent to have correspondence sent to you in the event that we are unable to contact you via telephone?	☐ Yes	☐ No

Would you like to be contacted via SMS (mobile text message) for: appointment reminders, recalls and other reminders?	☐ **YES** ☐ **NO**
Would you like a carer or family member to receive these SMS reminders on your behalf? **Name of person:**_____	**Please provide the mobile number you wish to have reminders sent to:** _____

Would you like to nominate someone who is permitted to access your medical information (e.g. pathology/radiology results) on your behalf?

PLEASE NOTE: If it is necessary for the Practice to contact you about a specific matter and you are unavailable, this person will be given any information appropriate.

☐ Yes ☐ No

If you have answered YES to the above question please answer below:

Name of person nominated:_____

Contact number of person nominated:_____

I declare that the information is true, correct and has my approval. **I understand I can withdraw my consent for any of the above at any time as long as it is done in writing. I understand that it is my responsibility, as the patient, to notify the practice if I have changed any of my contact details. The practice will not be liable for any event or circumstance that arises as a result of patient failure to update their details.**

Cowra Medical Associates

Name of patient: _____

We require your consent to collect personal information in accordance with the Privacy Act 1988. Please read this information carefully and sign where indicated.

This medical practice collects information from you for the primary purpose of providing the best possible health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. The information we may ask you to give us and hold is personal. Not providing the Practice with this information will restrict our capacity to provide you with the standard of medical care that you expect.

This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, consults/services that are funded and mandatory reporting, including compliance with Medicare Australia/ Health Commission requirement and other fund holder's requirements including Australian Primary Health Networks.
- Disclosure to others involved in your health care, including treating doctors and specialists and health professionals outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports of results returned to us following these referrals, all for the purpose of patient care.
- Emergency situation's whereby medical officers or hospitals require access to patient history for treatment purposes.
- Disclosure to other doctors in the practice, locums, registrars, doctors in training and medical accreditation surveyors attached to the practice for the purposes of patient care, teaching and accreditation.
- Disclosure to insurer, employer or solicitor where authorised to do so.
- Disclosure to others for medical defense purposes if necessary to establish, exercise or defend an equitable claim.
- Disclosures for research and quality assurance activities to improve individual and community health care and practice management. This information is de-identified.
- To assist in locating a missing person or a situation where the situation is life threatening.
- Where Mandatory reporting/ notification is required under law.
- For the purposes of My Health Record if applicable to patient.

Please note that we are obliged to comply with court orders and statutory requests for information for which your consent is not required.

CORRESPONDENCE

SMS messages are sent via the program HotDoc and is used to provide the practice with the ability to remind patients of appointments, changes in appointments, and to advise patients of recalls and reminders, where follow up may be required. These are transmitted over a public network.

Patients may opt out of receiving SMS notifications at any time in writing.

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EMAILS

By consenting to email correspondence patients are consenting to the practice corresponding with other service providers involved in their care (example specialists) via email where appropriate outside the practice.

All emails that are sent to external organisations / providers (i.e specialists, patient) carry the risk of being intercepted, as they are not able to be sent via secure email.

Email correspondence documents will be send via a password protected ZIP file and Emails will only be sent to verified email addresses.

We will preserve the contents of any email or secure message that we believe that we have a legal requirement to do so.

I have read the information above and understand the reasons why my information must be collected and disclosed. 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 may compromise the quality of health care and treatment given to me.

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 of.

I am aware that under the Privacy Act 1988 I have the 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 consent to the disclosure of information pertaining to my appointments, outstanding accounts and medical history/ information in the event I cannot be contacted to the persons nominated on the patient data sheet attached on page 2.

I acknowledge that I have read this form before signing it and that a member of staff of this practice has, at my request, clarified any aspect of it that I did not at first understand.

PRINT NAME: _____

SIGNATURE _____

DATE: _____