NEW PATIENT REGISTRATION FORM

Title: Name:

Preferred pronoun (if any): Date of Birth:

Address:

State: Post code:

Mobile Number: Landline:

Email address:

Next of Kin/Contact person: Their Phone number:

Medicare number: Ref. No:

DVA Card number:

Private Health Insurance: Fund Membership number:

Have you been with your Private Health Fund for more than 12 months? ✓

Does your private health fund cover you for admission into a private hospital? ✓

Your usual GP:

Referring Doctor (if not your usual GP):

What is the **main reason for your visit** to Restore Urology?

Please note we have a Nurse Practitioner, **Adam Cuthbertson-Chin**, who may be involved in your care, either independently (in consultation with your urologist), or in conjunction with your urologist.

Adam may contact you (at no additional fee) a week or two before your appointment with our urologists, to get more clinical details, and to check that we have all the information required for you to get the most from your appointment with Dr. Love or Dr. Blecher

Your preferences – for us communicating with you:

Messages and results

✓ Do not leave any messages please other than to return the call
✓ Please leave messages on home or mobile phone message service
Please leave results on home or mobile message service
(Please tick which apply to you)

Do you authorise anyone else to receive medical or financial information?

✓ No
(or)
✓ Yes – Name Relationship to you Phone number

Billing statements and financial correspondence

Any correspondence related to your bills will be automatically mailed to you home or emailed to your email address provided. Do you agree to this?

✓ Yes
(Or)
✓ No – please provide alternate address

Automated reminder calls/SMS Service

We currently utilise a reminder SMS system for your appointment date and time to be sent to your mobile phone.

✓ Yes, I would like a reminder
(Or)
✓ No, please don't remind me of my appointment details.

Individual Healthcare Identifier (IHI) and My Health Record:

Your IHI enables us to provide E-Scripts and link to your My Health Record. You need to opt out of this, as our standard is to link all patient's IHI.

✓ I want my IHI to be retrieved and linked with my medical record.
(Or)
✓ I DO NOT wish for my IHI to be retrieved and linked with my medical record.

Nurse Practitioner

✓ I understand, and agree with, the Nurse Practitioner being involved in my care, as detailed above.

Name:

Today's Date:

Signature:

PATIENT & PRIVACY CONSENT

We require your consent to enable us to handle personal information about you. Please read this form carefully and sign where indicated below. If you have any concerns or queries about this, please feel free to ask us for further explanation.

This practice collects information from you for the primary purpose of providing quality health care. We use this information in the following ways:

Administration purposes: including running the medical practice and for our insurer or Medical Indemnity Provider.

Billing purposes: including providing information to Medicare and your Private Health Insurance Fund and any other organization responsible for the financial aspects of your care.

Disclosure to others involved in your health care: including treating doctors, for medical tests and in the reports or results returned to us following the referrals.

Disclosure to enable recording on medical registers. For example, there is a requirement for mandatory notification of certain diseases to the Department of Health such as chlamydia, or gonorrhea.

Disclosure to other doctors in this practice, locums, training doctors and students may be attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for this purpose.

Research and Education: As a leading Australian provider in men's health, we value research as an important aspect to our work. We collect your data and may use it for purposes such as writing medical journal articles, book chapters, conference presentations or medical lectures. Any data used for this purpose is completely de-identified with no mention of any personal details, nor physical identifying features. Please let us know if you do not want your medical information used for this purpose. Your participation, or lack of, in research efforts will not affect your medical care.

We may make contact with you via mail or telephone to follow up on your condition, even if several years following your treatment.

I understand that I am not obligated 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 in the Privacy Policy, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out in the Privacy Policy handed to me today, subject to any limitations on access or disclosure that I notify this practice of.

I consent that this practice can collect personal information about me from other members of the treating team eg; hospitals, pathologists, radiologists, general practitioners, other specialists, para-medical therapists etc., to enhance the quality of the health care and treatment provided to me by Dr Gideon Blecher/Dr Chris Love/Adam Cuthbertson-Chin.

I consent that Dr Gideon Blecher/Dr Christopher Love/Adam Cuthbertson-Chin can disclose health information about me to an immediate family member or relevant others (spouse, de facto spouse, parent, child, guardian, person exercising enduring Power of Attorney, person nominated by an individual to be contacted in case of emergency). Such disclosures will be limited to the extent reasonable and necessary for the provision of health or on compassionate grounds.

I agree to the collection, use and disclosure of medical information collected about me as outlined in the Privacy Policy of this practice and the issues raised in this consent form.

Individual Healthcare Identifier (IHI) and My Health Record:

Your IHI is your personal number to identify you for medical purposes. All patients IHI's are automatically uploaded to your medical file, which enables services such as E-Scripts and access to My Health Record. This information is protected under the Healthcare Identifier's Act 2010. If you do not want this information shared, please opt out above.

Fees: In accordance with standard business practice, payment is requested at the time of consultation. Please note payment is required on the day of appointment. Any outstanding invoice that requires Debt Collection will attract an additional 20% to cover costs incurred.

There may be additional charges associated with your consultation, as recommended by your specialist, for tests such as radiology and pathology.

I have read this practice's Privacy Policy and understand the reasons why my information must be collected and agree to these privacy policies.

Name:

Today's Date:

Signature: