ColoRectalSA

Colorectal SA
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www.colorectalsa.com.au

PATIENT DETAILS

SURNAME (Family Name)

FIRST NAMES Dr ☐ Prof ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐

ADDRESS **P/CODE**

Preferred mode of contact Mobile ☐ Home Phone ☐ Email ☐ Text ☐ Mail ☐

EMAIL ADDRESS **OCCUPATION**

TELEPHONE Home Work Mobile

DATE OF BIRTH **AGE** **HEIGHT** **WEIGHT**

Are you privately insured for an operation in a private hospital? Yes ☐ No ☐

Do you have an excess with your health fund? Yes ☐ No ☐ Amount $

Date Of Joining Fund **Name Of Fund** **Fund Membership Number**

Medicare Number **Veteran Affairs Number** white ☐ gold card ☐

(If you are a white card holder please contact Veteran Affairs prior to your consultation to maintain if you will be covered for this visit or surgery if required).

Are you on a pension or health care card Yes ☐ No ☐ **Number**

Name Of GP **Referring Drs Name (if not GP)**

Next Of Kin (emergency contact person)

Relationship **Phone Number**

MEDICATIONS **please list prescribed and non-prescribed medications you are currently taking. Please do not write see referral list as this may require updating. Some medications may need to be ceased before your procedure. Your doctor will discuss this with you.**

Allergies To Medications

Are you currently a carrier of MRSA, VRE or any other multi resistant organism? Yes ☐ No ☐

CONSULTATIONS Medicare does not completely cover the cost of your consultation. There will be an out of pocket expense. **All fees are payable on the day of your consultation** - Eftpos saving facilities are not available at the country locations, payments can be made by either cash or credit card.

If a sigmoidoscopy or other minor procedure is performed during the consultation, an additional fee and gap may apply. Please discuss this with the Doctor if you wish.

TERMS OF PAYMENT - Patient or guardian to sign

I understand that payment in full of the account regardless of any Third Party Claim/Compensation Claim/Medicare Claim/Private Fund Claim is ultimately my responsibility. ☐

I acknowledge that the fees my Dr charges have been explained to me and that I am responsible for the payment of the fees at the time of my consultation. ☐

I/We agree to pay all expenses incurred in pursuing recovery of overdue amounts from me/us, including (but not limited to) legal fees, location administrative costs and any fees payable to debt recovery consultants. ☐

PLEASE CONTINUE OVER PAGE

RELEASE PATIENT INFORMATION TO NEXT OF KIN OR MINDER

The privacy of our patients is really important to us. There may be times where other members of your family or a minder may contact us seeking information about you or less likely we may need to contact a family member or minder if we cannot contact you for an urgent matter. We will only release information to persons outside of your healthcare team with your consent.

If you are happy for us to provide information as needed to a family member or other third party please nominate the person(s) to whom we are permitted to release information about you. You may also specify the type of information we are permitted to release by ticking as applicable.

Personal Details ☐ **Clinical Results** ☐ **Account Details** ☐ **Emergency Information** ☐

Appointment Details ☐ **Medical Information** ☐ **Other** (please specify below) ☐

I, _____ (Insert patient's name) Date of birth _____ hereby authorise Colorectal SA to release information as documented above to:

SURNAME (Family Name) _____

FIRST NAMES Dr ☐ Prof ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ _____

ADDRESS _____ **P/CODE** _____

TELEPHONE _____ **RELATIONSHIP TO PATIENT** _____

The reason or purposes of this release of information are as follows: (if applicable)

_____

I acknowledge that I have read and agree to the terms and conditions contained on both sides of this form.

Patient Signed _____ Date _____ **CLICK HERE TO EMAIL** EMAIL

Privacy Policy and Consent Form

We are very serious about your privacy and are committed to handling your information in accordance with the Privacy Act 1988 (Cth) and in particular the Australian Privacy Principles. The law gives you certain privacy rights in relation to information that you give to this medical practice. We need your consent to collect personal information about you. The fact that you have come here implies that you consent to us knowing about your health situation either for a particular event or for your general medical care. This form explains what your rights are over the use we make of the information and how we may disclose it to other medical service providers.

This privacy policy clearly explains how we handle health information and is available on request. You can also access this policy on our website www.colorectalsa.com.au.

The information we may ask you to give us is very personal. But not having it will restrict our capacity to provide you with a standard of medical care that you expect.

Please carefully read the following information about privacy issues then sign this form where indicated over the page. It will go on your file and you may examine it or change it at any time.

Collection & Disclosure

The main reason we collect information from you is so we can assess, diagnose and treat your illness properly and be pro-active in your health care. We will collect your health information directly from you but we may also collect information about you from a third party, for example from other health service providers, a family member or legal guardian. We will also use the information you provide in the following ways:

- Administration of this medical practice
- Billing including compliance with Medicare and Health Insurance requirements
- Disclosure to others involved in your healthcare, including doctors and specialists outside this practice who may become involved in treating you. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals. If necessary, we will discuss this with you.
- Disclosure to others for medical indemnity purposes if necessary.
- Disclosure to other doctors 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 these purposes, and we will put a note on your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. This practice participates in ongoing audit of activity outcomes particularly in relation to Colorectal Cancer & we participate in the Bi-National Colorectal Cancer Audit (BCCA – refer to website). All identifying information is removed from personal health information prior to being used for these purposes.
- Digital images may be used to record your condition and treatment and in a de-identified form for teaching purposes.

Data Quality & Security

We will endeavor to ensure that all personal information we collect, use or disclose is accurate, complete and up-to date. If your details change or you believe our records are not up to date and/or accurate please contact us.

Access

You have a right to have access to the health information that we hold in your health record. We will grant access unless the Privacy Act 1988 (Cth) or other relevant law allows us or requires us to refuse such access. We may charge a fee to recover reasonable costs associated with supplying information to you. If you would like to access your personal information please contact us on 82329115 or admin@colorectalsa.com.au.

Use of Identifiers

We will only use your Medicare number for the purpose of billing for medical services provided. Similarly we would not use or disclose any other government identifying number which you may have given us for any other purposes.

Anonymity

Where lawful and practicable, you have the option of using health services without identifying yourself.

Trans border Data Flows

Your information will not be transferred outside Australia unless that country has a similar privacy regime or only with your consent.

Complaints

If you have any concerns about the way we have handled your personal information then please contact our practice manager. We prefer that your complaint is in writing. It is our intention to resolve any complaint fairly and as quickly as possible. If you are unhappy with the response provided by us, you may refer your complaint to the Office of the Australian Privacy Commissioner.

PATIENT'S ACKNOWLEDGEMENT:

I have read this form and understand why collecting information about me is necessary. 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. I also understand that failure to provide this medical practice with all the information it needs may restrict the practice's ability to provide the quality of health care and treatment that I want.

I am aware that I have the right to access the information collected about me, except in circumstances where access might legitimately be withheld. I understand I will be given 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 about which I notify this practice now or at any future time.

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