

Patient Registration Details for Melbourne Children's Clinic

| | | | |
|---|---------------------|--|-----------------------|
| Child's Surname | Child's Given name: | | |
| Known as: (Nickname) | Language/s spoken: | | |
| Date of Birth: / / Current Age: | Sex: | M | F |
| Aboriginal & Torres Straight Islander status | | | |
| Court Orders / Legal Status: None Yes (If yes, please describe) | | | |
| Child's Residential Address/s: | | | |
| Mother/Guardian's Full Name: | | Date of Birth (for online claiming) / / | |
| Home / Mobile No. | | Email Address: | |
| Occupation: | | Work Phone: | |
| Residential Address: (If different from child) | | | |
| Father/Guardian's Full Name: | | Date of Birth (for online claiming) / / | |
| Home / Mobile No. | | Email Address: | |
| Occupation: | | Work Phone: | |
| Residential Address: (If different from child) | | | |
| Would you like an SMS reminder of your appointment? Y N If yes (1 only): Mother Father | | | |
| For Medicare online claiming we require parent and child details: | | | |
| Medicare number: | | Expiry Date: | |
| Father Reference No. | | Mother Reference No. | Child's Reference No. |
| Private Health Insurance: Yes No | | Extras: Yes No | |
| Fund: | | Membership No. | |
| Referring General Practitioner: | | | |
| Other Health Professionals / Services Involved: | | | |
| Allergies: Yes No | | Immunisations up to date: Yes No | |
| Medications: | | | |
| School / Childcare Name: | | Year Level: | |
| Siblings / Ages: | | | |
| Current Concerns / reason(s) for attending Melbourne Childrens Clinic | | | |

Continued next page...

PRIVACY INFORMATION AND CONSENT

We require your consent to collect personal information about you and your child. Please read the following information about privacy issues, practice requirements and fees carefully, and sign where indicated below.

The Melbourne Childrens Clinic collects information from you regarding your child for the primary purpose of providing quality health care. We ask you about you and your child's personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your child's' health care needs.

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

- Administration purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclose to others involved in your child's 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 reports or results returned to us following the referrals.
- Disclosure to other doctors in the practice, locums, medical students and by Registrars attached to the practice for the purpose of patient care and teaching.
- We may also need to communicate with teachers, allied health providers and other professionals involved with your child. Please let us know if you do not want your records accessed for these purposes. This will be noted accordingly.
- In an emergency situation where it is in the best interest of your child's health care we would disclose appropriate information if requested to do so.

PARENT/GUARDIAN ACKNOWLEDGEMENT

I have read the information above and understand the reasons why this information must be collected. 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 might compromise the quality of the health care and treatment given to my child.

I am aware of my right to access the information collected about 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 limitation on access or disclose that I notify the practice of.

I agree to abide by the following practice procedures:

- It is my responsibility to make sure I have a current referral from my G.P. for each visit
- If I fail to attend an appointment and/or do not give more than 24 hours notice of my cancellation, I may be charged a non-attendance fee as per the policy
- My child must be in attendance at all appointments (if not, a Medicare rebate is not claimable)
- Patient x-rays will be destroyed if they have not been collected more than two years after the date of service

I understand that the cost of the consultation is above the Medicare schedule fee, which means that I will incur an out of pocket expense. I agree to pay the account in full at the time of the consultation.

I have read this form before signing it and a member of staff has, at my request, clarified aspects of it that I have not understood.

Name of Patient.....

Name of Parent/Guardian

Signature of Parent/Guardian **Date:** / /

Complaints

Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with us. If you are still dissatisfied you can contact the Federal Privacy Commissioner at:

**Level 8 Piccadilly Tower
133 Castlereagh Street
Sydney NSW 2000**

Privacy Hotline: 1300 363 992

Website: www.privacy.gov.au