Bondi Respiratory & Sleep

# PATIENT REGISTRATION FORM

Suite 508, Level 5, Harley Place
251 Oxford St, Bondi Junction
**Mail** PO Box 678, Bondi Junction 1355

**P** (02) 8072 4115
**F** (02) 9410 0770
**E** reception@bondirespiratory.com.au

## PERSONAL CONTACT DETAILS

**TITLE**

☐ Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Dr ☐ Others

**SURNAME**

**GIVEN NAME/S**

**PREFERRED NAME OR NICKNAME**

☐ Male ☐ Female ☐ Non Binary
**GENDER**

**DATE OF BIRTH**

**RESIDENTIAL ADDRESS**

**POSTAL ADDRESS IF DIFFERENT**

**PHONE - MOBILE** (OR PREFERRED CONTACT NUMBER)

**PHONE - HOME**

**PHONE - WORK**

**EMAIL**

**POSTAL ADDRESS**

## YOUR NEXT OF KIN AND EMERGENCY CONTACTS

**CONTACT NAME**

**CONTACT PHONE**

**RELATIONSHIP TO PATIENT**

**OTHER INDIVIDUALS APPROVED BY YOU TO MAKE APPOINTMENTS ON YOUR BEHALF**

**NAME & MOBILE NUMBER**

## GENERAL PRACTITIONER

**GP NAME**

**CLINIC NAME**

**CLINIC ADDRESS**

**SUBURB**

**POSTCODE**

## REFERRING DOCTOR

**GP / OTHER**

☐ GP ☐ Other

**REFERRING DOCTOR'S NAME**

**CLINIC NAME**

**CLINIC ADDRESS**

**SUBURB** **POSTCODE**

**OTHER DOCTORS INVOLVED IN YOUR CARE (NAME / SPECIALTY / SUBURB)**

## MEDICARE AND BILLING DETAILS

CARD NUMBER

| | | | |
|---|---|---|---|
| ☐ | **MEDICARE** | REFERENCE | EXPIRY |
| ☐ | **DVA** | DEPT. OF VETERANS AFFAIRS NUMBER | COLOUR |
| ☐ | **PRIVATE HEALTH** | PRIVATE HEALTH FUND | EXPIRY |
| ☐ | **PENSIONER CONCESSION CARD** | COLOUR | EXPIRY |
| ☐ | **WORKCOVER** | CLAIM NUMBER | CASE MANAGER & CONTACT NUMBER |

**WILL THE PATIENT BE PAYING THE ACCOUNT**

☐ Yes ☐ No

**ACCOUNT HOLDER NAME** **ACCOUNT HOLDER - CONTACT PHONE**

**ACCOUNT HOLDER DATE OF BIRTH** **RELATIONSHIP TO THE PATIENT**

## FEE SCHEDULE

**OUR FEES**

We believe we provide a high level comprehensive and compassionate assessment of your respiratory and sleep health. We take the time each patient needs to ensure we understand their needs and explain the suggested management plan. Our fees reflect this service. Pensioner rates available to Australian government-issued Pensioner Concession Card holders only by displaying your card.

Our fee rates can be found on our website: http://www.bondirespiratory.com.au/fees-policies

**PLEASE NOTE:**

- Payment is due at the time of consultation via EFTPOS or Credit Card.
- No cash is kept on premises and change cannot be given.
- You will be issued with a receipt allowing you to claim the rebate from Medicare.
- Alternatively, we can process your claim for a Medicare Rebate electronically and have it deposited directly into your bank account if you have pre-registered your details with Medicare. See http://www.humanservices.gov.au/individuals/subjects/medicare-claiming

**NON MEDICARE-ELIGIBLE PATIENTS**

If you do not have a medicare card, are from overseas, or are attending for a workplace assessment, you will not be able to claim a medicare rebate and the above charges still apply.

**Do not attend the practice if you have new-onset respiratory symptoms. A tele-consultation can still take place instead and there is no need to cancel the appointment.**

☐ **I understand and accept the conditions of the Fee Schedule**

## CANCELLATION POLICY

Bondi Respiratory & Sleep is a busy specialist practice and our appointments are in high demand.

Our Cancellation Policy is designed to ensure fairness to both patients who are kept waiting for appointments as well as our doctors who are striving to meet the demand for their services.

Your appointment time is reserved especially for you. We do not double-book or over-book our clinics. All patients are given the time needed to provide a thorough and detailed medical assessment.

We understand that at times appointments need to be changed.

**UNDER THIS CANCELLATION POLICY, OUR DOCTORS APPRECIATE YOUR CO-OPERATION AS BELOW:**

- A minimum of 24 hours notice prior to your scheduled appointment time is required for cancellation or changes to appointment times.
- Patients not attending or cancelling their appointment within 24 hours of their scheduled appointment time will be charged a non-attendance fee.
- The non- attendance fee for a standard appointment is $100 for a new consultation and $50 for a follow up consultation.
- Please note no subsequent appointments will be booked until the non-attendance fee is settled.

☐ **I understand and accept the conditions of the Cancellation Policy.**

## PRIVACY POLICY

Due to the Federal Privacy Act 1988, we require your written consent to collect personal information about you. This practice collects your information in order to identify your medical record and provide an accurate, quality health service. Please read this information carefully and sign where indicated below.

We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat you. We collect information about you including but not limited to: your name, address, date of birth, email and contact details; Medicare number, DVA number and other government identifiers; Other health information including notes of your symptoms, diagnoses and treatments, specialist reports, appointment and billing details, your prescriptions and pharmaceutical purchases, your healthcare identifier, and information about your race, sexuality or religion within the context of your health service.

We may need to collect information from third parties where the Privacy Act or other law allows it, and this may include but is not limited to previous doctors, health care workers, pathology or x-ray services, hospitals, the MyHealth Record system, electronic prescription services, Medicare, your health insurer, the Pharmaceutical Benefits Scheme, for the primary purpose of providing quality healthcare. This means that we will use the information you provide in the following ways:

- *Best assess your health care needs and provide medical treatment.*
- *Administration purposes in running our practice. We may need to contact you using phone numbers provided by you. We may need to send documents, pathology and radiology referrals or letters to the email address provided by you.*
- *Billing purposes and debt collection, including compliance with Medicare and Health Insurance Commission requirements.*
- *Disclosure to others involved in your care, including treating doctors, specialists and hospital booking staff outside this practice. This may occur through referral to other doctors, surgery at hospitals, for medical tests and in the reports or results returned to us following the referrals.*
- *Collection of data for research purposes. This information is used to improve our treatment protocols, which will enable us to improve our quality of care. The data is kept in a secure manner and only staff involved in the research has access to them. You may be contacted at some time in the future for follow up purposes. No information that can be used to identify you will be included in any publication of the research results. You may withdraw from the research at any time.*
- *For legal related disclosures as required by a court of law.*
- *To comply with any legislative or regulatory requirements, for example, notifiable diseases or child protection legislation.*
- *If you have a My Health Record, to upload your personal information to, and download your personal information from, the My Health Record system.*
- *Accreditation and quality assurance activities to improve individual and community health care and practice management.*
- *You may be contacted for follow up in the future to ensure the follow up of any medical conditions.*

*You have the right to see any health information we hold about you as well as the ability to correct any details that are not accurate.*

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I have read the information above and understood the reasons why my 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 health care and treatment provided to me. I am aware of my right to access the information collected about me, except in circumstances where access might legitimately be withheld. I understand I will be given an expl`anation in these circumstances. I understand that if my information is used for any other purpose than set out above, my further consent will be obtained.

I give permission for my personal information to be collected, used and disclosed as above including to be contacted via phone, SMS, email and teleconference.

I consent to all handling of my information by this practice for the purpose set out above, subject to any limitations on access or disclosure and I notify this practice as of

☐ **I have read the above information and voluntarily give my consent.**

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**FULL NAME**

**DATE**

**SIGNATURE OF PATIENT**