



CONFIDENTIAL PATIENT INFORMATION SHEET

PERSONAL DETAILS

TITLE: _____ FIRST NAME: _____ MIDDLE NAME: _____
 SURNAME: _____ KNOWN AS: _____
 ADDRESS: _____
 SUBURB: _____ STATE: _____ POSTCODE: _____
 DATE OF BIRTH: DD / MM / YYYY GENDER: _____ OCCUPATION: _____

COMMUNICATION DETAILS

TELEPHONE: _____ (H) _____ (W) _____ (M)
 EMAIL: _____
 NEXT OF KIN: Name: _____ Relationship: _____
 Phone No 1: _____ Phone No 2: _____

REFERRAL DETAILS

Where did you first hear about *The International Spine Centre*?

Health Professional (e.g. GP, Physiotherapist) Other Professional (e.g. Lawyer) Website theinternationalspinecentre.com Another patient Name _____

REFERRING DOCTOR: Name: _____ GP Specialist
 Address: _____ Referral Date DD / MM / YYYY

USUAL GP (If Different): Name: _____
 Address: _____ Phone: _____

HEALTHCARE DETAILS

MEDICARE NO: Ref No: Expiry Date MM / YYYY
 PRIVATE FUND: _____ Membership No: _____
 (if applicable) Level of Cover: Top Hospital Basic Hospital (may have exclusions) Extras Only
 DVA CARD NO: _____ Gold White Orange
 (if applicable)

WORKCOVER OR THIRD PARTY PATIENTS ONLY

CLAIM TYPE: WorkCover Third Party CLAIM NO: _____
 DO YOU HAVE A LETTER OF DETERMINATION? DATE OF INJURY DD / MM / YYYY
 CASE MANAGER: _____
 INSURANCE CO: _____ ADDRESS: _____
 EMPLOYER: _____ ADDRESS: _____

PRACTICE POLICIES AND GUIDELINES

Support People: Due to limited space in the waiting room and for the comfort and safety of all visitors, we request that you bring no more than one support person to the appointment.

CCTV: For the safety and security of *The International Spine Centre's* visitors, staff and resources, closed circuit television is in operation throughout publicly accessible areas of the practice.

SMS Reminders: An SMS reminder of an upcoming appointment will be sent to patients who have provided a mobile phone number. Please tick this box if you **do not** wish to receive these reminders.

Missed Appointments: If you are unable to keep your appointment, please notify us immediately. We require 24 hours notice for cancellations. Failure to notify us within this timeframe will result in a non-attendance fee up to the equivalent cost of the missed appointment.

Gap Payments: *The International Spine Centre* is a private practice that charges fees above the Medicare schedule. We ask for full payment of your account on the day of your consultation. EFTPOS facilities are available.

Third Party (incl. RTWSA) Payments: Claims require a valid claim number and letter of determination/funding approval. Full payment is required on the day when a claim number/funding has not been approved. You are liable for all services that have been provided that are subsequently not paid by the nominated third party.

Overdue Fees: You are responsible for all reasonable expenses (including debt collection and legal fees) we incur during the collection of any overdue amounts.

PRIVACY POLICY

The International Spine Centre aims to provide high quality patient care. In accordance with privacy legislation and maintaining confidentiality and trust, we wish to inform you that any information collected about you requires your consent.

Diagnosis and treatment of your condition may be communicated between practice staff, specialists and other multi-disciplinary health care providers or organisations involved in your care. This includes ongoing referrals to continue your care. Your information may also be used for:

- Teaching and research
- Billing and collection of professional fees
- Accreditation and quality assurance
- Work-related or medico-legal reasons (*including providing information relating to your injury or condition to RTWSA, employer's claims agent or self-insured-employer*).

Information will only be requested in order that healthcare services can be provided to you.

You can write to us to request access to information held about you. There will be an administrative fee charged for this service.

Legislation may prevent certain types of information from being disclosed to you. Under these circumstances, an explanation will be provided to you.

Should you have any concerns about confidentiality please approach a member of *The International Spine Centre* team.

I **do not** consent to my personal information being disclosed to the following:

PATIENT AGREEMENT AND CONSENT

I agree to the policies above and consent to *The International Spine Centre* collecting my personal information.

Name (please print)

Signature

Date