Panaceum Medical - Panaceum Seacrest - Allied & Industrial Health

New Patient Registration & Consent

Welcome to our practice, please read and complete the following prior to your appointment.
Thank you!

PATIENT DETAILS							
Title		Surname		Given Name/s			
Date of Birth	___ / ___ / _____	Sex	Male / Female / Other	Ethnicity			
Address (Res)				State	___	Post Code	
Address (Postal)				State	___	Post Code	
Home Ph		Work Ph		Mobile Ph			
Would you like to receive **SMS Reminders** for appointments?				Yes / No			
Panaceum Group would like to send you your important health reminders and health promotions via email or text.				☐ Please tick if you wish to receive electronic correspondence.			
Email (Where possible use email unique to you, i.e. not work)							
Do you identify as Aboriginal or Torres Strait Islander?				Yes / No			
Private Health Fund		Membership Number					
Religion							

HEAD OF FAMILY, NEXT OF KIN AND EMERGENCY CONTACT DETAILS			
Head of Family (if patient <18yo)		Date of Birth	___ / ___ / _____
Next of Kin		Relationship	
Next of Kin Phone number			
Emergency Contact		Relationship	
Emergency contact Phone number			

TRANSFER OF MEDICAL RECORDS FROM YOUR PREVIOUS DOCTOR

If you would like your notes or health summary sent to Panaceum, **please request a transfer form from the front desk**.

OUR FEE STRUCTURE

- We are a **private billing practice**, and all fees are required to be paid on the day, unless prior arrangements have been organised.
- Any service requested by you may incur an out-of-pocket fee.
- Please initial here that you have read and understood our fee structure. ☐

Office Use Only: Type of Photo ID Observed_____ - Initial: _____

CONSENT TO COLLECT, USE, STORE AND SHARE INFORMATION

The Privacy Act 1988 requires medical practitioners to obtain consent from their patients to collect, use and disclose that patient's personal information.

1 COLLECTION AND STORAGE

This means we will collect information that is necessary to properly advise and treat you. Such necessary information may include:

- full medical history;
- family medical history;
- ethnicity;
- contact details;
- Medicare/private health fund details;
- genetic information; and
- billing/account details.

The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources, for example:

1 other medical practitioners, such as former GPs and specialists;
2 other health care providers, such as physiotherapists, occupational therapists, psychologists, pharmacists, dentists, nurses; and
3 hospitals and Day Surgery Units.

Both our practice staff and the medical practitioners may participate in the collection of this information.

In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent.

If you do not want to share all or some of your information with us, this may have a significant impact on our ability to care and treat you. We ask that you let us know of your wishes as soon as possible.

Once your information is collected, it is stored securely, with passwords to restrict access to certain information. Our computer system is maintained and regularly backed up to maintain the integrity of the information we hold about you.

2 USE & DISCLOSURE

Once collected, the practice staff will use and disclose your information for purposes such as:

- account keeping and billing purposes;
- referral to another medical practitioner or health care provider;
- sending of specimens, such as blood samples or pap smears, for analysis;
- referral to a hospital for treatment and/or advice;
- advice on treatment options;
- the management of our practice;
- quality assurance, practice accreditation and complaint handling;
- to meet our obligations of notification to our medical defence organisations or insurers;
- to prevent or lessen a serious threat to an individual's life, health or safety; and where legally required to do so, such as producing records to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases.

In some circumstances, a child aged 16 may be considered mature enough to provide their own information and to set limits on its disclosure. This may mean that legally, we cannot share information with their parent / legal guardian. We will not share or transfer information to any overseas organisations without your written permission.

3 ACCESS

You are entitled to access your own health records at any time convenient to both yourself and the practice. Access may include receiving a copy of all or part of your record or meeting with the treating doctor to go through the record together or the provision of a summary of your care.

Access can be denied where:

- to provide access would create a serious threat to life or health;
- there is a legal impediment to access;
- the access would unreasonably impact on the privacy of another;
- your request is frivolous;
- the information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings; and
- in the interests of national security

If we deny you access to all or part of your health record, we will provide you with a written explanation why access has been denied.

We ask that, where possible, your request be in writing. We may impose a charge for photocopying or for staff time involved in processing your request. Where you dispute the accuracy of the information we have recorded you are entitled to correct that information. It is our practice policy that we will take all steps to record all of your corrections, and place them with your file but will not erase the original record.

4 PRACTICE PRIVACY POLICY

Available on request or visit our website www.panaceum.com.au/privacy-policy.

DISCLOSURE OF INFORMATION TO A 3RD PARTY

I provide my consent for the following individuals/companies to have access to my personal medical information as follows. Please select what sort of access you allow, by circling the corresponding boxes below.
(Please leave blank if you do not want third party access to your records.)

Name			Relationship	
Access	Complete / Partial	If partial, please specify:	Communication about & collection of test results	Collection of correspondence, i.e. prescriptions
Name			Relationship	
Access	Complete / Partial	If partial, please specify:	Communication about & collection of test results	Collection of correspondence, i.e. prescriptions

It is important for you to inform the practice or your doctor of any changes or exceptions to the above as soon as possible.

CONSENT

PLEASE READ EACH STATEMENT CAREFULLY AND TICK THE BOX IF YOU AGREE	
I have read the information above and understand the reasons why the information must be collected	
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me. If I do not want to provide information or put limitations on access or disclosure, I will discuss these with the practice beforehand.	
I am aware of my rights to access information collected about me, except in circumstances where access may be legitimately withheld. I understand I will receive an explanation of why the information is being withheld in these circumstances.	
I understand that if my information is to be used for any other purposes other than those set out above, my further consent will be obtained.	
I consent to the handling of my information by the practice for the purposes set out on this form.	
I understand that depending on the age of my child, and given my child's right to privacy, in the clinical judgment of the doctor treating my child I may be prevented from access to information regarding my child's healthcare.	
I understand that if I request access to information held about me, I may be charged a fee to cover the administrative costs in providing access.	
I understand and consent to be contacted and receive reminders about my healthcare and management	
OR	
I am unsure and would like to discuss further with someone from the medical practice before signing	

Patient name			
Signature (Patient or Parent / Guardian)		Date	__ / __ / __
Parent / Guardian Name			