Gastroenterology Specialists Melbourne

32 Beatty Avenue,
Armadale VIC 3143
Tel. (03) 9069 3206
Fax. (03) 9069 3207
gsmelbourne.com.au
contact@gsmelbourne.com.au
gsmelbourne@argus.net.au

CONFIDENTIAL PATIENT INFORMATION

Surname:_____ **Given names:**_____

Preferred name:_____ **Preferred Pronouns:** _____

Address:_____

Suburb:_____ **State:**_____ **Postcode:**_____

Date of birth:_____**Phone:**_____

Email Address: _____

Next of kin:_____ **Phone:**_____

Relationship:_____

Medicare No. _____ _____ **Reference No.: (No. next to your name)**_____

Private Health Fund:_____ **Membership No.** _____

Heath Care/Pension/DVA Card Number:_____
Type (circle) Health Care Card/Aged Pension/DVA/Other

Usual GP (if different from above) _____**Usual GP Phone:**_____

Usual GP Clinic:_____

Are there any other medical practitioners you would like to have copied on correspondence apart from your referring doctor and usual GP? Please list below

Name Clinic Phone

_____

_____

_____

Please turn over....

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CONSENT TO COLLECT PATIENT INFORMATION

Gastroenterology Specialists Melbourne collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

Our policy is to protect your privacy and this information is only disclosed to other members of your treating team where necessary.

We communicate via post, fax telephone and email. If you wish to gain access to information about you held by this office, please contact us in writing.

The doctors at GSM prefer not to do medico-legal work. Should they be required to do so, they use a predetermined scale of fees for reports, court appearances and preparation time which can be provided on request.

I understand the reasons why my information must be collected.
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 me.
I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
I give permission for my records to be used for the purposes of audit, teaching and research with the understanding that I would not be personally identified in any way.
I understand that if my information is to be used for any purpose other than the above, my consent will be sought.
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 of which I may notify this practice.
I agree to be personally liable for payment of fees if any claim against a health fund, workcover or third party is rejected.
If I fail to attend an appointment, I understand I may be charged a fee of $100.

Signed _____ **Date:** _____

Patient Name (Please print) _____