mounties care

Integrative Health Clinic
New Patient Form

Non-Attendance Fee

We understand at times you may not be able to make your appointment.

We kindly ask that you notify the practice at least 24 hours before to cancel your appointment, if you fail to do so you may incur a non-attendance fee.

We appreciate and thank you for your understanding.

I have read and understood this policy. Signature: _____

Privacy

Your private information is at all times treated confidentially with care and in accordance with the Australian Privacy Principles (AAPS). A copy of our Privacy Policy is available on request.

I consent to receiving Appointment Reminders via SMS ☐ YES ☐ NO

Appointment reminders- notifications to you to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment.

I consent to receiving health reminders via SMS ☐ YES ☐ NO

Health reminders- notifications to you to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due;

I understand it is my responsibility to ensure all personal contact information is current and correct. You can update your details at any time with our reception staff.

Personal & Health Information Consent

We respect your rights to privacy and take our privacy obligations seriously. We comply with the Australian Privacy Principles, found under the Privacy Act 1988 (Cth). Our Privacy Policy can be obtained from:

- www.invitationtohealth.com.au
- Reception Staff
- By calling (02) 4322 0700

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

- Invitation to Health collects information from you for the primary purpose of providing you healthcare services. We require you to provide us with your personal and health information such as your medical history so that we may provide our services to you.
- We will use the information to effectively communicate with third parties including Medicare Australia, private health insurers, government departments and other practitioners involved in your healthcare

I have read and understand why my information is collected and how it is used. I acknowledge that I am not obliged to provide any information requested of me, but the failure to do so may compromise the quality of care provided to me.

Patient Signature: _____ Date: _____ / _____ / _____

Patient / Guardian Signature: _____

Guardian Relationship: _____

Do you require a translator? ☐ YES ☐ NO

Title: _____ Family Name: _____ Given Name: _____

Date Of Birth: _____ / _____ / _____ Gender: _____

Street Address: _____

Suburb: _____ Postcode: _____

Mobile Phone: _____ Home Phone: _____

Work Phone: _____

Email Address: _____

To tailor appropriate care, it is important for us to know if you identify as someone from a culturally & or linguistic diverse background.

If you do, please elaborate

_____

You concider yourself to be: ☐ Aboriginal ☐ Torres Strait Islander Origin ☐ Aboriginal and Torres Strait Islander

Medicare Number: ☐☐☐☐☐☐☐☐☐☐ Reference Number: ☐

Expiry Date: _____ / _____

Are you a DVA Patient? If yes please provide your details below.

DVA Number: ☐☐☐☐☐☐☐☐☐

Expiry Date: _____ / _____

Pension Type: ☐ Concession Card ☐ Healthcare Card ☐ Commonwealth Seniors Health Card

Pension Number: ☐☐☐☐☐☐☐☐☐☐☐☐

Expiry Date: _____ / _____

Next of Kin

Name: _____ Relationship: _____

Phone: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: _____