

REGISTRATION, PRACTICE INFORMATION AND CONSENT FORM

Prefix	<input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Mrs <input type="checkbox"/> Mx <input type="checkbox"/> Mr <input type="checkbox"/> Dr <input type="checkbox"/> Other:		
First name		Middle name	
Surname		Known as	
Maiden name			
Home Address			
Suburb			
State		Postcode	
Postal Address			
Suburb			
State		Postcode	
DOB			
Biological Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex:		
Gender Identity	<input type="checkbox"/> Woman <input type="checkbox"/> Man <input type="checkbox"/> Another Descriptor:		
Preferred Pronouns			
Mobile phone		I consent to receive SMS / Voicemail <input type="checkbox"/> Yes <input type="checkbox"/> No	
Home phone		I consent to receive SMS / Voicemail <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work phone		I consent to receive SMS / Voicemail <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email address			
Medicare <input type="checkbox"/> Medicare Ineligible	Number		
	Reference	Expiry	
Health fund <input type="checkbox"/> Uninsured	Name		
	Member No.	Reference	
DVA Gold card?	<input type="checkbox"/> Yes <input type="checkbox"/> No - go on to Referring Doctor		Member No.
Referral provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Usual GP <input type="checkbox"/> Tick here if same as Referring Doctor	Name		
	Address		
	Telephone		
	<i>N.B. Following your appointment, a report will be sent to your referring doctor. If you do not want correspondence sent to your referring doctor, you will need to provide us with a new referral.</i>		
Marital status	<input type="checkbox"/> De facto <input type="checkbox"/> Married <input type="checkbox"/> Same sex partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed		
Indigenous status	<input type="checkbox"/> Aboriginal origin <input type="checkbox"/> Torres Strait Islander Origin <input type="checkbox"/> Neither		
Country of birth		Language	
Ethnicity			
Occupation			
Emergency contact	Name		
	Occupation		
	Telephone	DOB	
	Email		
	I consent for this person to liaise on my behalf in case of emergency <input type="checkbox"/> Yes <input type="checkbox"/> No		
Partner <input type="checkbox"/> Tick here if same as Emergency contact	Name		
	Occupation		
	Telephone	DOB	
	Email		
	I consent for this person to liaise on my behalf for non-clinical matters <input type="checkbox"/> Yes <input type="checkbox"/> No		

REGISTRATION, PRACTICE INFORMATION AND CONSENT FORM

The following pages are to inform you of the various policies and procedures that may affect you as a patient when attending or accessing our services. Certain aspects of our provision of service to you requires your consent. You will be required to re-sign this entire document at least every two years to keep it current.

PRIVACY STATEMENT The personal and health information that is provided by you and recorded in your Electronic Health Record will be collected by Alana Healthcare for the primary purpose of providing you with medical care. Your information is collected and held in accordance with the Australian Privacy Legislation and the Health Privacy Principles under which you have rights of access and correction. Information about your privacy rights is available at www.privacy.gov.au. If you would like to read our full Privacy Policy, please ask at Reception.

Your medical record is a permanent legal document and we take its security very seriously. Records can only be removed from our premises on a court subpoena, statutory authority, search warrant, coronial summons or similar. If information is requested by any other third party (e.g. partners, relatives, solicitors, government departments, insurance companies, etc), it must be accompanied by an original written authorisation from you.

The only people who will access your medical record without getting your permission first are the ones who really need it - the health professionals directly involved in your treatment. You can request access to your medical record at any stage. Your request must be made in writing, and approved by your treating practitioner.

If required, we can, on written request, provide you or a person nominated by you, with a printed or electronic copy of your record. Charges may apply.

I have read and understood Privacy Statement. Yes No

CANCELLATION POLICY An SMS will be sent for all scheduled appointments at least two working days prior. If you do not have a mobile phone or elect not to receive an SMS, our staff will instead telephone you to confirm your appointment. **Any appointment not confirmed by return SMS or phone call by 12:00pm the working day prior will automatically be cancelled.** Late cancellations will be considered as anyone who cancels their confirmed appointment after 12:00pm the working day before. A "Did Not Attend" (DNA) is someone who misses a confirmed appointment without cancelling it. If you need to cancel your appointment please notify us by 12:00pm the working day before, by either responding to the SMS or phoning 9009 5255 to speak to a staff member or leave a message. Cancellations via email will not be accepted. N.B. We are not open on weekends.

Cancellation fees **Late cancellation:** 50% of consultation fee **DNA:** 100% of the consultation fee

I have read and understood Cancellation Policy. Yes No

COMMUNICATIONS CONSENT We may, on occasion, wish to communicate with you and/or third parties on your behalf, and require your consent to do so. Communications may be by phone or other electronic means, such as email or SMS. All communications are performed with particular regard to the privacy and confidentiality of your health information, and in accordance with privacy legislation.

Email communications with us is **NOT ENCRYPTED** and may be used for general matters, appointments, pathology results, recalls, and other matters as needed. We will also automatically send to you by email a copy of any correspondence from us to your referring doctor, which contains your personal medical information. Email does not replace appointments with your practitioner. Consenting to communicate with us by email means that:

- You acknowledge that the privacy and confidentiality of your health information may be compromised when communicating by email without encryption.
- Only non urgent matters shall be communicated by email. Urgent matters should always be communicated by phone.

Do you consent to Email communication to the email address indicated on Page 1? Yes No

Medicare/Private Health Fund We may need to liaise with Medicare or your private health insurer on your behalf for the purposes of performing insurance cover checks, or for provision of Informed Financial Consent.

Do you consent for Alana Healthcare to liaise with Medicare/Private Health Fund? Yes No

Health Recalls If you attend our practice for a Cervical Screening Test, colposcopy, IUD insertion or pessary insertion or other relevant service you will automatically be placed on our Recall register. When your next appointment is due, we will contact you in line with your communications consent. There may also be other health events which your practitioner flags as important and for which you need to be recalled.

Do you consent to be contacted for Health Recalls as requested by your practitioner? Yes No

Research/Evaluation We may wish to contact you to invite you to participate in research, or to request your permission to use your health information for research purposes, or to evaluate the service and/or medical treatment that you have received.

Do you consent to be contacted at a future date for Research/Evaluation? Yes No

Fertility Consults Patients attending for fertility services who proceed to IVF/ART will need to have their file transferred to Monash IVF for continuation of their care. This includes, but is not limited to, your referral, consultation notes, ultrasounds, pathology results and any other fertility related interventions relevant to your care.

Do you consent to the transfer of your file to Monash IVF for the continuation of your care? Yes No

REFERRAL TO OTHER SERVICES/THIRD PARTY PROVIDERS It may be necessary for your clinician to refer you to an external provider for diagnostic tests/investigations (e.g. ultrasound, x-ray, pathology, etc.). If you are referred for further diagnostic tests **you will be liable to pay any fees** attached to those services. Pathology collected or requested by us will incur a charge from the laboratory. Alana Healthcare cannot quote you for the cost of external services.

Diagnostic tests/investigations ordered as part of your medical treatment will be followed up by the requesting practitioner only, unless otherwise indicated. As a general rule, you will only be contacted if the returning result is abnormal in any way, requires treatment, repeat/ongoing investigation, or referral to another specialist/service. Our staff will assist you in making any necessary arrangements and organising a referral, prescription or appointment if needed.

Non-clinical staff are not permitted to release results to patients. Copies of results will be released to patients only when reviewed and signed off by the requesting practitioner and any findings communicated to the patient.

I have read and understood Referral to Other Services/Third Party Providers Yes No

INFORMED FINANCIAL CONSENT

Medical		
Consultation with Doctor 45-60 minutes		\$660
Consultation with Doctor 30-45 minutes		\$495
Consultation with Doctor 15-30 minutes (standard first)		\$330
Consultation with Doctor ≤15 minutes (standard follow up)		\$165
Consultation with Practice Midwife 30-45 minutes		\$50 out of pocket
Physiotherapy		
Consultation 45-60 minutes (standard first)	Senior Physiotherapist / Physiotherapist	\$260 / \$220
Consultation 30-45 minutes	Senior Physiotherapist / Physiotherapist	\$180 / \$160
Consultation 15-30 minutes (standard follow up)	Senior Physiotherapist / Physiotherapist	\$140 / \$120
Consultation ≤15 minutes	Senior Physiotherapist / Physiotherapist	\$100 / \$80

The fees detailed above are an **estimate** of the cost of a consultation only with one of our practitioners. Medical consultations are charged in 15 minute blocks or part thereof. Any services required in addition to this, including procedures (such as colposcopy, vulvoscopy or IUD insertion), pathology, imaging or any other associated costs, are separate and in addition to the above. All fees are payable on the day of service.

Patients accessing Telehealth will be required to **prepay** for these services. To be eligible to claim a Telehealth service with Medicare, you must still have a valid referral letter, and return a signed copy of this document prior to your appointment. We will then issue your invoice and submit your claim to Medicare on your behalf.

All face to face services are **payable on the day**. With your permission we will submit your claim to Medicare on your behalf.

As with any medical service, circumstances may arise during the consultation where it may be necessary to arrange additional medical services and if this happens there may be additional costs to you that are not covered by this estimate.

The above fees are for provision of medical services only. A separate charge will apply for administrative services including, but not limited to, the provision of a medical report, provision of medical records for insurance, claim or other purposes, reprint of a prescription, or reprint of a request form. Fees will be advised at the time of making the request. Medicare rebates DO NOT apply for administrative services.

Please note, our fees increase marginally each 1st January.

I have read and understood Informed Financial Consent Yes No

YOUR ACKNOWLEDGEMENT I have read and understood the above information and agree to abide by the policies of Alana Healthcare. I reserve the right to change my consent at any point on written request. I understand that my acknowledgement of the above will be recorded in my Electronic Health Record.

Your signature

Today's date

If you are not the patient but are signing on behalf of the patient, please complete the below:

Firstname:	Lastname:	Relationship:
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