Synergy UROLOGY

11/5 Innovation Parkway, Birtinya, QLD, 4575
reception@synergyurology.com.au
07 5208 9185
synergyurology.com.au

Mr / Mrs / Ms / Miss Surname……………………..………….First…………………………..………..Age…………..D.O.B…………………………….

Address……Post Code ………………………

Home Phone ……………………………………………….Bus Phone ……………………………Mobile Phone ……………………………………

Email Address……..

Your Occupation………..

Referring Doctor …………………………………………………..Date of Referral……………………………………………………………………….

Referring Doctor's Address ……..

Any Other Treating Doctors ………………………………………………………………………… ………………………………………………..

Are You Diabetic? ☐ Yes ☐ No

Medicare Number …………………………………………………………Expiry Date………………………... Reference No. ……………………………..

Pension or Health Care Card Number: ……………………………….. Expiry Date……………………………………………………………………...

Next of Kin (person to be contacted or carer)

Surname ……………………………………………………….First Name…………………………………………(Relationship)……………………….

Address ☐ (as above) or ……………………………………………………………………………………………Post Code ………………………..

Home Phone ……………………………………………….Bus Phone ……………………………Mobile Phone ……………………………………

Private Insurance ☐ Yes ☐ No Name of Health Fund …………………………………………………………….

Fund Membership Number …………………………………….. Have you been in this fund for more than one year? ☐ Yes ☐ No

If no, what date did you join…………………………………

Veterans' Affairs Type of Card Held Repat (Gold) Card Number ……………………….. Expiry Date ………………..

Part (White) Card Number ………………………… Expiry Date ………………

Agreement: I am directly responsible for all charges incurred. I am responsible for all non-covered services.
I authorise release of any medical information to insurance companies as may be needed to process my claim.
I authorise the use of the fax for sending and receiving of any relevant medical reports/records if required.

Signed ……………………………………………………………………….. Date ……………………………….

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PRIVACY INFORMATION AND CONSENT FORM

The law gives you certain privacy rights in relation to information that you give to this medical practice. We need your consent to collect personal information about you. The fact that you have come here implies that you consent to us knowing about your health situation. The information we may ask you to give us is personal. But not having it will restrict our capacity to provide you with the standard of medical care that you expect.

Please read carefully the following information about privacy issues then sign this form where indicated below.

The reason we collect information from you is so we can assess, diagnose and treat your illness properly and be pro-active in your health care. We may also use the information you provide in the following ways:

- Administration of this medical practice.
- Billing, including compliance with Medicare and H.I.C requirements.
- Disclosure to others involved in your health care, including doctors and specialists outside this practice who may become involved in treating you. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Disclosure to others for medical defence purposes if necessary.
- Disclosure to other doctors in the practice, locums and Registrars attached to the practice for the purpose of patient care.
- Disclosure for quality assurance and research activities to improve individual and community health care and practice management.

You will be informed when such activities are being conducted, you may decline to have any involvement.

Patient's Acknowledgment:

I have read this form and understand why collecting information about me is necessary.

I understand I am not obliged to provide any information requested of me, but that failure to provide this medical practice with all the information it needs may restrict the practice's ability to provide the quality of health care and treatment that I want.

I am aware that I have the 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 consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure about which I notify this practice now or at any future time.

I acknowledge that I have read this form before signing it and that a member of staff of this practice has at my request clarified any aspects of it that I did not at first understand.

Signed ………………………………………………………………………. Date ……………………………….....