IMPORTANT INFORMATION FOR PATIENTS OF QUINNS MINDARIE SUPER CLINIC

COLLECTION OF PERSONAL INFORMATION
PRIVACY POLICY
CANCELLATION FEE
DE-IDENTIFIED DATA SHARING

We require your consent to collect personal information about you and for you to acknowledge you have had the opportunity to read our privacy policy and understand there is a cancellation fee for appointments not attended or cancelled within 2 hours. *Please read this information carefully, and sign where indicated below.*

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and be pro-active in your health care. As part of the provision of health care services to you, we may send you appointment reminders, clinical reminders and clinical communications from time to time. We will also use the information you provide in the following ways;

- Administrative purposes in running our medical practice – clinical reminders, clinical communications, appointment reminders and health awareness.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals. If necessary, we will discuss this with you.
- Sharing of de-identified patient health data with Government health agencies and some third-party providers to improve health services offered to our patients. If you do not consent to your de-identified data being shared please advise our reception team.

- **I am aware that this practice has a privacy policy on handling patient information, which I have had the opportunity to read and understand, and consent to my information being used as per the policy.**
- **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 acknowledge that the practice will use contact details provided by me (as updated by me from time to time) to communicate with me.**
- **I understand at least 2 hours' notice is required if I cannot attend my appointment. I acknowledge that a fee of $25 will apply if I do not attend my appointment or fail to give 2 hours' notice.**

Patient Name: …… DOB: ……

Signed: …… ……
Patient /Parent /Guardian *Parent/Guardian name (please print)*

Witnessed: …… Date …… ☐ Health Identifier look up completed
Medical Receptionist

WELCOME TO QUINNS MINDARIE SUPER CLINIC

Please complete ALL details on both sides. Please PRINT clearly

Title *please circle* Mr Mrs Ms Master Miss

Surname _____

Given Name _____ Preferred Name: _____

Date of Birth _____ Gender Identity: ☐ Male ☐ Female ☐ Other

Country of Birth _____

Street Address _____

Suburb _____

Postal Address _____

Suburb _____

Home Phone _____ Mobile_____

Email _____

My preferred contact method for all clinical reminders is:

☐ EMAIL ☐ SMS ☐ LETTER

If you have provided a work email please sign to agree to comply with our privacy policy

Signature _____

Emergency Contact Name _____ *Ph* _____

Relationship _____

Private Health Fund: Yes/No Fund Name: _____

Concession Card Number _____ *type* _____ *exp* _____

How did you hear about our medical practice? _____

Please indicate whether you identify yourself as Aboriginal, Torres Strait Islander or both.

☐ Australian Non Indigenous ☐ Torres Strait Islander but not Aboriginal

☐ Aboriginal but not Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander

Please complete overleaf