

**MEDALLIANCE**

572 Stanley Street,
Albury NSW 2640
Ph: 02 6023 1388
Fax: 02 6023 1299
admin@medalliance.com.au

PATIENT REGISTRATION FORM

Title: _____ First Name: _____ Surname: _____
 Date of Birth: _____ Home Phone: _____
 Street Address: _____ Mobile Phone: _____
 _____ Email: _____
 Suburb: _____ Are you happy with teleconferencing? Y N
 State: _____ Postcode: _____ If yes, what is your Skype ID: _____

PERSON RESPONSIBLE FOR THE ACCOUNT

Patient: Parent: Other: Details: _____
 3rd Party (Workers Compensation, Workcover, TAC (Vic), MVA etc.) Please complete details of your claim.
 Date of Injury: _____ Claim Number: _____
 Injury Details: _____
 Insurer: _____ Case Manager: _____
 Address: _____
 Employer and Address: _____

HEALTH BENEFITS AND MEDICARE

Medicare No.: _____ Ref No.: _____
 Private Health Insurer: _____ Ref No.: _____ Membership No.: _____
 DVA Card No.: _____ Colour: _____
 Pension No.: _____ Health Care Card No.: _____

MEDICAL AND EMERGENCY CONTACT

Usual GP: _____ GP Clinic: _____
 Emergency Contact: _____ Relationship: _____
 Phone: _____ Mobile Phone: _____

ALLERGIES / ADVERSE REACTIONS TO ANAESTHETIC

Do you have any allergies? Y N
 If YES list allergies: _____
 Have you or your family had any adverse reactions to anaesthetic? Y N
 If YES provide detail: _____



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PATIENT INFORMATION, EMAIL, SMS CONSENT AND FINANCIAL RESPONSIBILITY

As a patient of MedAlliance, we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs. We aim to protect the privacy and secure storage of your health information.

MedAlliance is not a bulk billing practice. Payment is expected on the day. On booking your appointment, the administrative staff will be able to give you an estimation of the cost. Delay in payment may result in referral to a debt collection agency.

We require your consent to collect personal information about you and to use the information you provide in the following ways.

1. Administrative purposes in running our medical practice.
2. To inform next of kin/emergency contact for transport or emergency purposes which may include obtaining consent for necessary treatment should I not be able to provide consent.
3. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
4. Disclosure to others involved in your healthcare 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 referrals.
5. For quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
6. To comply with any legislative or regulatory requirements eg notifiable diseases.
7. For reminder letters which may be sent to you regarding your health care and management.
8. For the release and/or collection of health information about you from your GP and other service providers associated with your care according to Australian Privacy Principles. In medically urgent situations, it may be necessary to provide the information to your health care providers without your consent.

The doctors and practice staff will take all reasonable measures to ensure confidentiality and may contact you by phone, fax and/or email. MedAlliance however, will not guarantee the confidentiality of unsecure communication methods. Appointment reminders will be sent via SMS unless we are instructed otherwise.

- I have read the information above and understand the reasons why my information must be collected.
- I consent to release of my medical information to other service providers involved in my health care where necessary.
- I consent to correspondence from MedAlliance to be sent to the email address and phone numbers I have provided.
- I agree to be responsible for any/all fees, accounts, invoices incurred by myself from MedAlliance. I am aware that I am liable to pay any collection fees should debt collection be involved.

Date: _____

Name: _____

Date of Birth: _____

Signature: _____

Please see information on our website www.medalliance.com.au regarding our full Privacy Policy, Collection of information, SMS policy and Financial Responsibility. If you would like a copy of this to take with you, please ask staff at front desk. Thank you.