PATIENT INFORMATION

Title: Dr / Mr / Mrs / Ms / Miss	Surname:
First Name:	Middle Name:
Sex: M / F / I / U	Date of Birth:
Postal address:	Suburb: Post Code:
Mobile Phone No:	Home Phone No:
Email address:	Work Phone No:
Medicare No:	Valid until date: No. next to your name:
DVA Card No:	Type: Gold / Yellow/ White
Pension No:	Health Care Card No:
Do you have Private Health Insurance? Y /N	Health Fund:
Health Fund Card No:	Do you have Hospital cover? Y /N
Family Doctor Name:	Phone Number:
Address:	Suburb:
Occupation:	Is this a Workcover/Insurance Claim? Y / N
Next of kin full name:	Relationship:
Mobile Phone No:	Home/Work phone No:
Person responsible for the account (NB: Only complete if person responsible for payment is not the patient)	
Surname:	First name:
Date of Birth:	Relationship to patient:
Postal address:	Suburb: Post Code:
Home/Work phone No:	Mobile phone No:
Medicare No:	Valid until date: No. next to your name:

Account Payment Responsibility

Please be advised that out-of-pocket expenses may be incurred. It is Southern Sleep policy that full payment of your account is required on the day of service. For services covered by Medicare on online claim will be lodged. Eligible rebates will be paid directly into your bank account, providing this is registered by Medicare. For services not covered by Medicare, full payment on the day of service is required. A collection fee may be charged for overdue accounts. Thank you for your assistance.

Patient/Guardian Signature: _____Date: _____

PATIENT INFORMATION

COLLECTION & DISCLOSURE OF PATIENT INFORMATION

The Privacy Act of 1988 requires all health practitioners to obtain consent from their patients to collect, use and disclose patients' information.

Southern Sleep collects your personal information and medical history for the purpose of providing quality medical care and so that we may properly assess, diagnose, treat and be proactive in your healthcare needs.

Disclosure and collection may be required for administrative purposes in running our medical practice including Medicare, DVA, 3rd party transcription and non-medical information for debt collection if applicable.

For further information visit privacy.gov.au. Southern Sleep Privacy Policy is available at southernsleep.com.au

PATIENT CONSENT

- ○ I consent to the disclosure to and collection from medical/specialist practitioners, allied health practitioners, institutions and hospitals that may require information about my medical history in order to assess/treat the particular condition for which I have consulted the medical specialist/practitioner.
- ○ I consent to disclosure and collection that may also be required for administrative purposes as listed above.
- ○ In emergencies, I consent to Southern Sleep collecting information from my relatives or friends.
- ○ I am aware that this practice has a privacy policy on handling patient information.
- ○ I acknowledge that I have read this form and understand why collecting information about me is necessary. Before signing this form, a member of this practice, at my request, has clarified any aspects needed.

Patient/Guardian Signature: _____ Date: ____ / ____ / _____

AUTHORITY TO OBTAIN MEDICAL INFORMATION

I, _____

Authorise the release of my health information as requested to Southern Sleep.

Patient/Guardian Signature: _____ Date: ____ / ____ / _____

Witness Signature: _____ Witness Name: _____

AUTHORITY TO RELEASE MEDICAL INFORMATION VIA EMAIL

I authorise Southern Sleep to release my medical information via electronic mail (email) to my email and/or the email of my family member/carer detailed above, and as necessary, any health practitioner involved in my treatment.

I am aware that Southern Sleep does not have encrypted email software and cannot guarantee that information transmitted via email will not be intercepted by other parties. By signing this form, I agree to not hold Southern Sleep or its employees responsible for any breach in confidentiality that may occur by someone else accessing the information contained in any emails sent to or from Southern Sleep regarding my personal health information.

I understand that reasonable means will be used to protect the security and confidentiality of the email. All concerns to and from me regarding my personal health information will be part of my medical record and can be viewed by Southern Sleep doctors and support staff. My email will not be forwarded outside the office without my consent or as required by law.

This release may be revoked at any time by written notice and is valid until such revocation is received by Southern Sleep.

Patient/Guardian Signature: _____ Date: ____ / ____ / ____

OFFICE USE ONLY **Patient ID #**: _____**Registered by**: _____**Date**: ____ / ____ / ____