PATIENT INFORMATION FORM

Title:	Mr	Mrs	Miss	Ms	Dr

Surname:		First Name:		Middle Name:	
Have you been known previously under another name?	☐ Yes ☐ No			Details:	
Are you of Aboriginal or Torres Strait Islander descent?	☐ Yes ☐ No			Date of Birth:	

Residential Address:		
Suburb:	Post Code:	Country:
Postal Address: (If different to Residential Address)		

Phone - Home:	Mobile:	Email:
Next of Kin: Relationship:	Address:	Phone:

Medicare Number:		Ref No.		Expiry:	
Private Health Fund:		Membership Number:			
Department of Veteran Affairs number:		Gold ☐ White ☐		Expiry:	
Pension / Health Care Card Number:		Pension ☐ Health Care ☐		Expiry:	

Guardian Details (Must be completed if patient under 16)

Name:		Date of Birth:
Postal Address:		
Relationship to patient:		
Phone - Home:	Mobile:	Work:

Overseas Visitor

Address in Australia:	
Credit Card Details - (Please circle) Visa / Debit / Mastercard	
Name on Card:	CVC / CCV:
Card Number:	Expiry:

Complete this section only if applicable:

Workers Comp Claim Details - Claim Type (Please circle): Workers Compensation / Motor Vehicle Accident / Public Liability / Other

Claim Number:		Date of Accident:
Insurance company name:		Phone:

Employment Details

Employer's Name:		Phone:
Address:		
Contact:		Mobile:
Email:		

IMPORTANT INFORMATION - MUST READ

Has your accident been reported to your employer/MVIT? **YES/NO**
Have you completed the necessary claim forms at your place of employment/MVIT? **YES/NO**
Is this a re-occurrence of a previous injury for which a Worker's Compensation / MVIT claim was made? **YES/NO**

PLEASE NOTE: Please be advised that our invoices for out-patient examinations performed in relation to Workers Compensation and WA Motor Vehicle claims will be directed to the Insurer/Employer for payment. If the Insurer/Employer declines the claim and invoice the patient will be responsible for total payment of all costs for examination/s. If the claim is declined, the patient acknowledged that they will be responsible for the total amount outstanding and that for MRI examinations there may not be a Medicare Rebate, upon which you will be responsible for paying the total account. I undertake to pay Global Diagnostics, the full amount upon request within 7 days. In the case that a radiology examination has been done whilst admitted as a Public Inpatient or Accident & Emergency patient please disregard the above.

I hereby authorise representatives of Global Diagnostics to divulge to my employer, or the employer's insurer, radiology reports or information in relation to my claim for Worker's Compensation/MVIT.

Global Diagnostics (Australia) Pty Ltd trading as Global Diagnostics is a Private Practice. Payment of your account is required on the day of your examination.

Signed by Patient OR Guardian: _____ Date: __/__/____

Witnessed: _____ Date: __/__/____

PLEASE READ & SIGN BACK PAGE

PATIENT CONSENT TO COLLECT & DISCLOSE INFORMATION

The Privacy Act 1988 requires medical practitioners to obtain consent from their patients to collect, use and disclose that patient's personal information.

Collection
This means we will collect information that is necessary to properly advise and treat you. Such necessary information may include:

- Medical history
- Billing/account details
- Medicare/private health fund details
- Family, social & employment history
- Name, address & contact details.

The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources, for example:

- Hospitals and Day surgery Units
- Other medical imaging practices
- Other medical practitioners, such as your GPs and specialists
- Other health care providers, such as physiotherapists, psychologists, pharmacists, dentists, nurses.

Both our practice staff and medical practitioners may participate in the collection of this information.

In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent.

Use & Disclose
With your consent, the practice staff will use and disclose your information for purposes such as:

- Account keeping and billing purposes
- Collecting unpaid examination fees due
- Referral to another medical practitioner, health care provider or medical imaging provider
- Sending of specimens for analysis
- Referral to a hospital for treatment and/or advice
- Advice on treatment options
- The management of our practice
- To prevent or lessen a serious threat to an individual's life, health or safety
- Where legally required to do so, such as producing records to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases
- To supply results/reports/recommendations to your referring doctor pertaining to your medical management
- To provide information or medical reports in relation to workers compensation or motor vehicle claims to insurers
- Quality assurance, practice accreditation and complaint handling
- To meet our obligations or notification to our medical defence organisation or insurers.

Access
You are entitled to access your own health records at any time convenient to both yourself and the practice. Access can be denied when:

- Your request is frivolous or vexatious
- There is a legal impediment to access
- In the interests of national security
- The access would unreasonably impact on the privacy of another
- To provide access would be a serious threat to your life or health
- The information relates to anticipated or actual legal proceeding and you would be entitled to access the information in those proceedings

Consent
I provide my consent for Global Diagnostics (Australia) Pty Ltd trading as Global Diagnostics to collect, use and disclose my personal information as outlined above.
I provide consent for my results/images to be sent to my medical practitioner, health care provider or medical imaging provider by facsimile or electronic transmission.
I provide consent for messages to be left with immediate family members/defacto partner (e.g. Appointment confirmation).
I understand that I am entitled to access my own health records except where access would be denied as outlined above.
I understand that I may withdraw my consent as to use and disclose of my personal information (except when legal obligations must be met).

Print Name: _____

Signed by Patient OR Guardian:_____ **Date:** __/__ /____

Witnessed: _____ **Date:** __/__ /____
Global Diagnostics (Australia) Representative