PLEASE COMPLETE – AS SHOWN ON MEDICARE CARD

Please tick ✓ ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr Other:_____

First Name: _____ Middle Name: _____

Surname:_____ Known As: _____

Address: _____

Date of Birth:_____ Gender: _____

Contact Numbers: H) _____ W)_____ M)_____

Email Address:_____

Marital Status: _____ Occupation: _____

PLEASE CIRCLE – YES / NO DO YOU give consent/ permission for HHS/HHRC staff to contact or provide information to my Next of Kin or emergency contact – I am aware I can withdraw this permission in writing at anytime.

Signed:_____ DATE: _____

Emergency Contact/Next of Kin: _____

NOK Phone No: _____ Relationship: _____

REFERRED BY: _____

Address: _____

Phone No: _____

GENERAL PRACTITIONER: _____

Address: _____

Phone No: _____

Membership Details:

Medicare No: __ __ __ __ __ __ __ __ __ __ Ref (number next to your name): __ Expiry: _____

Private Health Fund: _____ Member No: _____

Pension Card Number: _____ Card Colour: _____ Expiry: _____

Veterans' Affair Card Number: _____ Colour: _____

Defence EPID: _____

Is it a possibility your condition may be a Workers' Compensation Claim? ☐ No ☐ Yes

If Yes, you will need to complete an additional form

Please Turn Over

CONSENT FORM

We require your consent to collect personal information about you. Please be advised because we share a data base with Hunter Hand Rehabilitation Centre, they also have access to your clinical records. 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, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including your health fund, treating doctors and specialists outside this medical practice who have treated you or may treat you in the future. This may occur through referral to other doctors, hospital emergency departments or for medical tests and in the reports or results returned to us following the referrals or for audit by your health fund. If these providers share information with us, this will also form part of your clinical record.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.
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 am aware of my 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 understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.
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 of which I may notify this practice.

I acknowledge that:
I can change or withdraw my consent at any time.
Hunter Hand rehabilitation Centre has access to my Clinic Records
I can access the Private policy by request or from Hunter Hand Surgery Website.

SIGNED: _____ DATE: _____

CONSENT FOR PHOTOGRAPHY
Clinical photography has many valuable uses. We utilise photographs of your hand and/or fingers to help in documenting progression of disease, determine effectiveness of management, to aid in clinical research and teaching and to facilitate communication between health practitioners.
Consent may be withdrawn at any time. Please read and indicate below your preferences: I give my consent to:

- clinical photographs/ video being taken of my hand or wrist ☐ Yes ☐ No

I give my consent for these photographs/videos to be:

- sent to my nominated treating doctor ☐ Yes ☐ No
- de-identified and shared with other medical practitioners for the purpose of obtaining an opinion ☐ Yes ☐ No
- de-identified and shared with other medical practitioners for teaching and education ☐ Yes ☐ No
- de-identified and used in research publications and presentations ☐ Yes ☐ No

I acknowledge that:
Clinical photographs obtained will be stored in a secure manner.
If I chose not to give permission for photographs to be taken, this may compromise the quality of treatment that can be offered to me.
I may obtain copies of my photographs at any time within reason.
I have had the opportunity to ask questions and understand how the use of clinical photographs may improve the quality of my treatment.

SIGNED: _____ DATE: _____

PATIENT NAME:
_____