**PLEASE COMPLETE – AS SHOWN ON MEDICARE CARD**

Please tick ✓ Mr. ☐ Mrs. ☐ Miss. ☐Ms. ☐ DR. ☐ Other: _____

First Name:_____ Middle Name: _____

Last Name: _____ Known As: _____

Address: _____

Date Of Birth: _____ Gender: _____

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

Email Address: _____

Marital Status: _____ Occupation: _____

**I give permission to contact my next of kin if required.** NO. ☐ YES. ☐

**I am aware I can withdraw this permission in writing at any time.**

Emergency Contact / Next of Kin Name: _____

Contact No._____ Relationship: _____

**Referred By:** _____

Practice: _____ Phone No. _____

**General Practitioner:** _____

Practice: _____ Phone No. _____

**Medicare No.** _____ Ref (no. next to name.) _____ Expiry: _____

**Private Health Fund:** _____ Member No. _____

**Pension Card No.** _____ Card Colour: _____ Expiry: _____

**Veteran's Affairs No.** _____ Card Colour: _____

**Defence EPID/DAN:** _____

**IS IT A POSSIBILITY YOUR CONDITION MAY BE A WORKER COMPENSATION CLAIM OR A CTP CLAIM?**

NO. ☐ YES. ☐

Claim No. _____ Insurer: _____

Case Manager: _____ Date of Injury: _____

Name of Employer at time of injury: _____

**Consent:**

We require your consent to collect personal information about you as a patient of Hunter Hand Surgery. Please be advised we share a database with Hunter Hand Rehabilitation Centre. Please read this information carefully and sign where indicated.

Hunter Hand Surgery collects information for the purpose of providing quality health care. We require you to provide us with a full medical history so we can assess, diagnose, treat and be proactive in your health care. We may use your information in the following ways.

- Administrative purposes
- Billing including compliance with Medicare, and Health Insurance Companies.
- Disclosure to other interested parties including your GP, other health care providers, Medicare and Health Insurance companies for the purpose of audit or additional health care requirements.

At Hunter Hand Surgery, we work closely with research institutes and universities. Occasionally patient information may be selected to be used in research development. If your condition is of interest with the research team, we will send you an invitation to consent to your information being used in a research capacity. Such research is always conducted according to ethical standards and your participation is voluntarily. Your withdrawal can be made at any time. *If you agree to the research team contacting you if your condition is of interest, please tick the box.*

☐ Agree ☐ Disagree

At Hunter Hand Surgery clinical photography has many valuable uses, including but not limited to documenting progression of disease, determining effectiveness of management, aid clinical research and teaching. Photographs and videos may be taken of your lower arm, hand and or fingers.

**Acknowledgements:**

- ☐ I acknowledge I have read the above information.
- ☐ I understand that I am not obliged to provide any information, but failure to do so may compromise the quality of health care.
- ☐ I am aware of my right to access my personal information.
- ☐ I understand how my information may be used.
- ☐ I acknowledge that I can change my consent at any time in writing.
- ☐ I acknowledge I can access the privacy policy at any time.
- ☐ I understand how my photographs may be used.
- ☐ I understand I have the opportunity to ask questions to help understand my medical condition, medical history, diagnostic images, policies and procedures and consent.

- ☐ **I understand that if my workers' compensation claim is denied or not approved, I will be liable for the fees.**

Name: _____ Date: _____

Signature: _____