Dr Alicia INNIS

draliciainnis.com

Patient registration

First name: _____ Surname: _____ Preferred name: _____

Date of birth: _____ Country of birth: _____

Medicare number: _____ Expiry date: _____

Private Health fund: _____ Membership number: _____

Aboriginal: ☐ or Torres Strait Islander: ☐ or Aboriginal and Torres Strait Islander: ☐ or neither: ☐

Address: _____

Suburb: _____State: _____Postcode: _____

Home phone number:_____ Mobile: _____

Occupation: _____

Emergency contact

Name: _____ Relationship to you: _____

Address: _____

Suburb: _____State: _____Postcode: _____

Home phone number:_____ Mobile: _____ Work number: _____

Parent / guardian / Next of kin (if different to above)

Name: _____ Relationship to patient: _____

Address: _____

Suburb: _____State: _____Postcode: _____

Home phone number:_____ Mobile: _____ Work number: _____

Occupation: _____

Use of email/phone calls

I understand that I can choose to receive a reminder about an upcoming appointment by email / phone call. This service is restricted to administrative purposes only to protect the privacy and confidentiality of patients as total security cannot be guaranteed. In providing an email address / phone number, I acknowledge the risks and consent for my email / phone number to be used for this purpose.

EMAIL ADDRESS (personal): _____

Dr Alicia INNIS

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Consent to collection of personal and healthcare information

As a patient of Dr Alicia Innis, you are required to provide her with your personal details and a full medical history, so that she may properly assess, diagnose, treat and be proactive in your health care needs. She aims to protect the privacy of your health information at all times. You can request a copy of her privacy policy, which includes information about the collection, use and disclosure of your health information. She requires your consent to collect your personal information, and its use for the following reasons:

- Administrative purposes
- Billing purposes (including compliance with Medicare and Department of Health requirements)
- Disclosure to others involved in your healthcare. This may include allied health professionals, other specialists, your general practitioner and other health practitioners. This may occur through referral to others or for medical tests and in the reports or results returned to me following referral.
- For quality improvement purposes to improve practice management (this will only be information that does not identify individual patients)
- To comply with regulatory or legislative requirements such as notifiable diseases or where the health and well-being of you or other/s is at significant risk of harm.
- For appointment reminders and recalls which may be sent to you via email or phone call regarding your healthcare and management.

You can decline to have your health information used in all or some of the ways outlined above, but it may influence Dr Alicia Innis' ability to manage your healthcare so as to provide the best outcome.

PLEASE READ EACH STATEMENT CAREFULLY AND TICK THE BOX IF YOU AGREE	
I have read the information above and understand the reasons why the information must be collected	
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me or if I provide information but want to put limitations on access or disclosure, I will discuss these with the practice beforehand.	
I am aware of my rights to access information collected about me, except in circumstances where access may be legitimately withheld. I understand I will receive an explanation of why any information is being withheld in such circumstances.	
I understand that if my information is to be used for any purposes other than those set out above, my further consent will be obtained.	
I consent to the handling of my information by the practice for the purposes set out on this form.	
I understand that if I request access to information held about me, I may be charged a fee to cover the administrative costs in providing access.	
OR	
I am unsure and would like to discuss with someone from the medical practice before signing	

Patient name: _____ Date: _____

Patient signature: _____

OR

Guardian name: _____ Date: _____

Guardian signature: _____