CompCare Specialist Centre
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www.compcare.com.au
Lvl 5, 120 Angas St, Adelaide SA 5000

Patient Information Form

(MR / MRS / MISS / MST / MS / DR / OTHER: _____) SURNAME _____

GIVEN NAME/S _____ D.O.B _____

ADDRESS _____

_____ POSTCODE _____

PHONE (HOME) _____ (WORK) _____ (MOBIILE) _____

Do you consent to receive SMS reminders from our practice? YES | NO

EMAIL _____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP_____

MEDICARE NUMBER ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ EXPIRY _____/_____ REF NO _____ (DIGIT NEXT TO NAME)

CONCESSION CARD _____ EXP _____/_____

DEPT OF VETERAN'S AFFAIRS (DVA) _____ GOLD / WHITE (PLEASE CIRCLE)

If the patient is under 18 years of age, the following information is required by Medicare:

CAREGIVER NAME _____ MEDICARE NUMBER __ __ __ __ __ __ __ __ __ __ EXPIRY __/__ REF NO __ DOB: _____

DO YOU HAVE PRIVATE HOSPITAL HEALTH INSURANCE? YES | NO

IF SO, HAVE YOU HAD YOUR HOSPITAL COVER FOR AT LEAST 12 MONTHS? YES | NO

FUND NAME _____ MEMBER NUMBER _____

REFERRING DOCTOR _____ CLINIC _____

REGULAR GP _____ CLINIC _____

Other health providers you would like to have included into correspondence:

DOCTOR NAME _____ CLINIC _____

DOCTOR NAME _____ CLINIC _____

***All patients must ensure that referrals are current prior to all appointments so that a Medicare rebate can be claimed ***

CONSENT TO COLLECT PATIENT INFORMATION

This medical practice collects information from you for the primary purpose of providing quality health care so that we may properly assess, diagnose, treat and be proactive in your health care needs. 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 treating doctors and specialists outside this medical practice.

I understand the reasons why my information must be collected. 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. I understand that if my information is to be used for any purpose other than the above, my consent will be sought.

CANCELLATION POLICY

I understand that failure to give 24 hours' notice prior to cancelling my appointment, or non-attendance without prior notice, will incur a $30-$50 non-attendance fee.

I understand that full payment of my account is my responsibility. I understand that failure to do so could result in debt collection which incurs additional charges payable by myself.

SIGNED ..... DATE .....