Patient Registration Form

Personal Details: Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐

Surname: …… First Name: ……

Address: ……

……Postcode:……

Telephone: Home: …… Work: …… Mobile: ……

Date of Birth: ……. / ……. / ……. Email: ……

Next of Kin Details (usually a partner, relative or close friend):

Name: …… Relationship:……..Phone No:……

Address:……

General Practitioner Details:

Name of GP: ……Clinic Name & Suburb: ……..

Medicare Details:

Medicare No: ……Reference No:…… Expiry Date: ……...

PLEASE NOTE THAT IT IS THE RESPONSIBILITY OF THE PATIENT TO PROVIDE A CURRENT REFERRAL, FROM EITHER A GENERAL PRACTITIONER OR AN OPTOMETRIST, BOTH OF WHICH ARE VALID FROM THE DATE OF ATTENDANCE AT THIS CLINIC HENCEFORTH 12 MONTHS. A REFERRAL FROM ANOTHER MEDICAL SPECIALIST IS VALID FOR 3 MONTHS.

IT IS NOT POSSIBLE TO CLAIM A REBATE FROM MEDICARE WITHOUT A CURRENT REFERRAL

Centrelink Pension Details: ***only applicable if government pension is sole source of income***

Pension Number: …….. Date commenced: …… Expiry: …….

Department of Veterans Affairs Details: White Card ☐ Gold Card ☐

DVA No: …… Expiry Date: ……...

Private Health Insurance Details: ***if applicable***

Name of Fund: ……Member No:……..

Fees: (as of 07/03/2011) ***This is not a bulk billing practice.***

Payment is required on the day of consultation & we accept cash, personal cheque, credit card or EFTPOS. We do not accept American Express or Diners. Our fees to do not exceed the AMA recommended fee.

First consultation	**$ 175.00**	**Medicare rebate**	**$ 72.75**
Further consultations	**$ 100.00**	**Medicare rebate**	**$ 36.55**
Paediatric consultation	**$ 250.00**	**Medicare rebate**	**$ 163.90**

Full Pensioners: (meaning you derive no other source of income other than a government pension).

First consultation	***$ 145.00***	***Medicare rebate***	***$ 72.75***
Further consultations	***$ 85.00***	***Medicare rebate***	***$ 36.55***

Please note that this discount is provided as a service by Peninsula Eye Centre, not Medicare or the Government.

NB: Additional charges may be payable if your ophthalmologist requires other testing to be undertaken.

DVA Patients:	**Gold Card**	**Fully covered by DVA**
	White Card	**DVA approval required**

Please refer over page

Patient Registration Form

PRIVACY LEGISLATION CONSENT FORM

We require your consent to collect personal details about you. Please read this information carefully and sign where indicated below.

In order to provide you with the highest standard of eye care, this practice is required to collect personal information from you. 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 pro-active in your health care needs.

We value the need to safeguard this information and would like to assure you that the information you provide will only be used in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your direct health care, including doctors and allied health providers outside this medical practice. This may occur through referral to other doctors, allied health providers, or for medical tests and in the reports or results returned to use following the referrals.

- I have read the above information 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 I receive.
- I am aware of my right to access the information collected about me, and it will be provided to me in accordance with the Federal Privacy Act 2001.
- I understand that if my information is to be used for any other purpose other than those detailed above, my further consent will be obtained.
- I acknowledge that I have read and agree to the fee structure of the practice.
- I consent to the use of the facsimile machine for sending and receiving my information as required.
- I consent to the

Patient Signature: .....

Date: .....

peninsula EYE CENTRE Vision Specialists