PATIENT REGISTRATION

Veritas Health Care Medical Centre

First name: ____ Surname:____

Preferred name:____________________ Sex at birth: Male/Female Gender identity: _______________________

Date of birth: _________________ Ethnicity: _______________________ Title: Mr/Mrs/Ms/Mast/Miss Other____

Aboriginal: ☐ or Torres Strait Islander: ☐ Both: ☐ Neither: ☐

Address: ____

Suburb: _____________________________ State: ____________________ Postcode: ________________

Postal Address: (if different from above) ____

Home phone number:________________ Mobile:_________________________ Work number:______________

Medicare Number: ___________________________________ IRN: ____ Expiry date: _______________

Pension Concession Card number: _______________________________ Expiry date: _______________

Health Care card number: ______________________________________ Expiry date: _______________

DVA Card Number: ____________________________ Type: ___________________

Private Health fund: _______________________ Membership number: _____________________

Occupation: ______________________________ Consent to update My Health Record? Yes ☐ No ☐

Next of Kin/ Parent / Guardian

Name: ____ Relationship to patient:____________________

Address: ____

Suburb: ___________________________State: ______________________Postcode: _________________

Home phone number:_______________Mobile:_____________________Work number:_______________

Emergency Contact ☐ Tick if same as above

Name: ____ Relationship to patient:_____________________

Address: ____

Suburb: ___________________________State: ______________________Postcode: _________________

Home phone number:_______________Mobile:_____________________Work number:_______________

CONSENT TO COLLECTION OF PERSONAL AND HEALTHCARE INFORMATION

As a patient of this medical practice, 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. We aim to protect the privacy of your health information at all times. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information. We require your consent to collect your personal information, and its use for the following reasons:

- Administrative purposes
- Billing purposes (including compliance with Medicare and the Dept. of Health and Ageing requirements)
- Disclosure to others involved in your healthcare. This may include allied health professionals, other specialists and health practitioners outside of this practice. This may occur through referral to others or for medical tests and in the reports or results returned to us following referral.
- Disclosure to other doctors in the practice for the purposes of patient care and teaching.
- For research and quality improvement purposes to improve individual and community health care and 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 reminders and recalls which may be sent to you via sms, email or letter 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 the practice's ability to manage your healthcare 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 and explanation of why the information is being withheld in these circumstances.	
I understand that if my information is to be used for any other 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 depending on the age of my child, and given my child's right to privacy, in the clinical judgment of the doctor treating my child I may be prevented from access to information regarding my child's healthcare.	
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 further with someone from the medical practice before signing	

Patient name: ____

Patient / Parent / Guardian signature: ____Date: _____________

Parent / Guardian name **[if minor]**: ____

Disclosure of Information to a Third Party

(e.g., partner, spouse, parent, sibling, carer, etc.)

I provide my consent for the following individuals/companies to have access to my personal medical information as follows:

Name: ______________________________ Relationship to patient: ______________________

DOB: ______________________ Patient signature: __________________________

Please mark the relevant boxes below to indicate the purpose for your consent

- ☐ Making or changing appointments
- ☐ Access results
- ☐ Talk to my GP
- ☐ Request scripts
- ☐ To make administrative changes to my record such as updating my contact details
- ☐ Access to medical records

Other, please specify: ____

Use of Email/SMS

I understand that I can choose to have information for routine reminders by email/sms. 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 /mobile phone number, I acknowledge the risks and consent for my email/mobile phone number to be used for this purpose.

EMAIL ADDRESS: ____

MOBILE NUMBER: ____

Appointment Policy [Summary]

If you are unable to keep your appointment, please let our Reception Staff know immediately so that we may offer the appointment to someone else.

A "No Show/Late Cancellation" is defined as missing an appointment without cancelling at least 24 hours before scheduled time.

Last minute cancellations are often difficult to fill, so we respectfully ask that you please inform us of any cancellation at least 24hrs beforehand. In cases of last-minute cancellations or missed appointments we reserve the right to charge you a non-attendance penalty fee of $40.

Patient / Parent / Guardian Signature: ________________________________

PRIVACY POLICY FOR VERITAS HEALTH CARE MEDICAL CENTRE

Introduction

This privacy policy is to provide information to you, our patient, on how your personal information (which includes your health information) is collected and used within our practice, and the circumstances in which we may share it with third parties.

Why and when your consent is necessary

When you register as a patient of our practice, you provide consent for our GPs and practice staff to access and use your personal information, so they can provide you with the best possible healthcare. Only staff who need to see your personal information will have access to it. If we need to use your information for anything else, we will seek additional consent from you to do this.

Why do we collect, use, hold and share your personal information?

Our practice will need to collect your personal information to provide healthcare services to you. Our main purpose for collecting, using, holding and sharing your personal information is to manage your health. We also use it for directly related business activities, such as financial claims and payments, practice audits and accreditation, and business processes (e.g. staff training).

What personal information do we collect?

The information we will collect about you includes:

- names, date of birth, addresses, contact details
- medical information including medical history, medications, allergies, adverse events, immunisations, social history, family history and risk factors
- Medicare number (where available) for identification and claiming purposes
- healthcare identifiers
- health fund details.

Dealing with us anonymously

You have the right to deal with us anonymously or under a pseudonym unless it is impracticable for us to do so or unless we are required or authorised by law to only deal with identified individuals.

How do we collect your personal information?

Our practice will collect your personal information:

1. When you make your first appointment our practice staff will collect your personal and demographic information via your registration.
2. During the course of providing medical services, we may collect further personal information. We participate in these activities and will access your personal information through Electronic Transfer of Prescriptions (eTP), My Health Record/PCEHR system, e.g. via Shared Health Summary, Event Summary.
3. We may also collect your personal information when you visit our website, send us an email or SMS, telephone us, make an online appointment or communicate with us using social media.

4. In some circumstances personal information may also be collected from other sources. Often this is because it is not practical or reasonable to collect it from you directly. This may include information from:

   - your guardian or responsible person
   - other involved healthcare providers, such as specialists, allied health professionals, hospitals, community health services and pathology and diagnostic imaging services
   - your health fund, Medicare, or the Department of Veteran's Affairs (as necessary).

Who do we share your personal information with?

We sometimes share your personal information:

- with third parties who work with our practice for business purposes, such as accreditation agencies or information technology providers – these third parties are required to comply with APPs and this policy
- with other healthcare providers
- when it is required or authorised by law (eg court subpoenas)
- when it is necessary to lessen or prevent a serious threat to a patient's life, health or safety or public health or safety, or it is impractical to obtain the patient's consent
- to assist in locating a missing person
- to establish, exercise or defend an equitable claim
- for the purpose of confidential dispute resolution process
- when there is a statutory requirement to share certain personal information (e.g. some diseases require mandatory notification)
- during the course of providing medical services, through Electronic Transfer of Prescriptions (eTP), My Health Record/PCEHR system (eg via Shared Health Summary, Event Summary).

Only people that need to access your information will be able to do so. Other than in the course of providing medical services or as otherwise described in this policy, our practice will not share personal information with any third party without your consent.

We will not share your personal information with anyone outside Australia (unless under exceptional circumstances that are permitted by law) without your consent.

Our practice will not use your personal information for marketing any of our goods or services directly to you without your express consent. If you do consent, you may opt-out of direct marketing at any time by notifying our practice in writing.

How do we store and protect your personal information?

Your personal information may be stored at our practice in various forms.

e.g. as paper records, as electronic records, as visual (X-rays, CT scans, videos and photos), as audio recordings.

Our practice stores all personal information securely.

-electronic format, in protected information systems / hard copy format in a secured environment. We use passwords, secure cabinets, confidentiality agreements for staff and contractors to prevent breech of patient privacy.

How can you access and correct your personal information at our practice?

You have the right to access and correct your personal information.

Our practice acknowledges patients may request access to their medical records. We require you to put this request in writing [and either post or deliver the request in person] and our practice will respond within a reasonable time. [in 30 days' time, $50 fees payable for full records]. Our practice will take reasonable steps to correct your personal information where the information is not accurate or up-to-date. From time-to-time, we will ask you to verify your personal information held by our practice is correct and up-to-date. You may also request that we correct or update your information, and you should make such requests in writing to Veritas Health Care Medical Centre or email reception@veritashealthcare.com.au

How can you lodge a privacy related complaint, and how will the complaint be handled at our practice?

We take complaints and concerns regarding privacy seriously. You should express any privacy concerns you may have in writing. We will then attempt to resolve it in accordance with our resolution procedure. email reception@veritashealthcare.com.au or write to The Practice Manager Veritas HC Medical Centre, 197 Rifle Range Road, Rangeway WA 6530, Telephone 08 99359490, Fax 08 99359510. We endeavour to achieve a turnaround timeframe specific to our practice processes of 30 days.

You may also contact the OAIC. Generally, the OAIC will require you to give them time to respond, before they will investigate. For further information visit www.oaic.gov.au or call the OAIC on 1300 336 002.

Complaint about privacy and confidentiality and access to personal information:

Office of the Australian Information Commissioner

Email: enquiries@oaic.gov.au

Facsimile: +61 2 9284 9666

Phone: 1300 363 992.

Post: GPO Box 5218 Sydney NSW 2001

Complaint about health care service or delivery:

The Health and Disability Services Complaints Office (HaDSCO)

Email: mail@hadsco.wa.gov.au

Facsimile: (08) 6551 7630

Phone: (08) 6551 7600 or 1800 813 583

Post: GPO Box B61 Perth WA 6838

<u>Privacy and our website</u>

We use secure emailing to request prescriptions and request appointments to be prebooked.

Our practice use passwords to avoid data insecurity.

<u>Policy review statement</u>

This privacy policy will be reviewed regularly to ensure it is in accordance with any changes that may occur. We will notify our patients when we amend this policy via reception posters.

Patient name: ____

Patient signature: ____ Date: ____________________

If minor,

Parent/Guardian's name: ____

Parent/Guardian's signature: __________________________________ Date: _____________________

Updated: 31/05/2023

Veritas Health Care Medical Centre

Appointment/Cancellation/No Show Policy

Appointments

Clinic visits are by appointment only. Please call 08 9935 9490 to book an appointment. The receptionist may ask about the reason for your visit. This helps us schedule the doctors' time more efficiently. Please arrive at least 15 minutes early for your first appointment. Patients who are late for any appointment may be asked to reschedule at the doctor's discretion.

Cancellations

We would like to thank you for being a patient in our clinic. We value all of our patients and strive to provide the best vision care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient who would like it. We know that your time is valuable. Except in the case of emergency treatment for another patient, you can expect us to be running on schedule. If you are unable to keep an appointment, we ask that you cancel at least 24 hours in advance. If this is not possible, call as soon as you can (at least 3 hours) so that another patient can be given your appointment time.

Missed Appointments (Non-Cancelled)

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without cancelling, someone else who could have been seen in your place is delayed unnecessarily. We track missed (non-cancelled) appointments. A "No Show/Late Cancellation" is defined as missing an appointment without cancelling at least 24 hours before scheduled time. There will be a charge for a missed or non-cancelled appointment. Insurance will not cover charges for no show or late cancellation fees. The $40 charge is in addition to any other charge you may have incurred. No refunds will be given. Repeated missed appointments may result in your doctor sending a letter discharging you from the practice. We will offer 30 days of emergent care only and transfer your medical records when you find a new doctor.

Payment

Payment is due in full at the time of service. No exceptions.

Patient name ____

Signature ______________________________ Date: ________________

If minor,
Parent/Guardian's name: ____

Parent/Guardian's signature: ____________________ Date: ________________