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| **PRIVATE AND CONFIDENTIAL Patient Registration and Authority Form** |

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| **PERSONAL DETAILS** | | |  |
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| Dr/Mr/Mrs/Ms/Miss/Master/(Military)Rank: \_\_\_\_\_\_\_ | | | Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_ |
| Sex: | Male  Female  Not Specified | |  |
| First Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
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| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | | Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Can we send you SMS reminder of appointments? Y / N | |
| Next of Kin (name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | |
| Referring Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Medicare and Health Fund Details** | | GP (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Medicare Card Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Position: \_\_ Expiry Date: \_ \_ / \_ \_ | |
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| **Private Health Fund**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Member Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Level of Cover (*please circle one option*):  **How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | BASIC / BRONZE / SILVER / GOLD / DIAMOND | |

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| **DVA / MILITARY** | **Workers Compensation/Third Party** |
| **DVA** | Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DVA Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DVA Card Colour (*please circle one*): ­­WHITE / GOLD | Claim Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Accident: \_\_\_/\_\_\_/\_\_\_\_ |
| ***White Card Holder:***  Accepted Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Rehab Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*  **MILITARY**  PMKEYS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Solicitor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DAN: \_\_\_\_\_\_\_\_\_\_\_\_ |  |
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| **PRIVACY STATEMENT** | |  | **CONFIDENTIALITY STATEMENT** | | |
| The information that you provide on all forms is used to assist us in assessing your pain/outcome. All information you provide will remain confidential. If you agree, your **anonymous**, de-identified health information (which does not identify you personally) may be entered into a database for audit/research purposes.  ***Consent (please tick one)***  I AGREE to my anonymous data being used for vital audit and research purposes Y  N  As a multidisciplinary clinic, our Practitioners work together to provide the best treatment approach for your recovery. Practitioner case conferences are held on a regular basis to discuss the care of patients as a team.  ***Consent (please tick one)***  I AGREE to my Practitioners at Capital Pain and Rehabilitation Clinic to discuss my care in formal case conference meetings, if required Y  N    ***Consent (please tick one)***  I AGREE for Capital Pain and Rehabilitation Clinic to forward information to my general practitioner, Insurance Company and other regular Health Professionals Y  N  Capital Pain and Rehabilitation Clinic has adopted the *Australian Privacy Principles* (APPs) contained in the *Privacy Act* *1988*. | | | | | |
| **DECLARATION**: |  | | | |  |
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| **PRIVATE PATIENTS/PENSIONERS I understand that I am required to pay for the initial consultation and any further consultation and therapy accounts at the time of my appointments.** | | | | | |
| **Fees: DAY SURGERY I understand that any fees NOT covered by my Health Fund are payable on admission, and any fees incurred during my stay are payable on discharge. I understand and agree to pay all hospital accounts, including the event where my Fund or Health Insurance claim should be denied for whatever reason.**  **PLEASE NOTE: Health Fund Day Hospital Excess requirements must be paid on admission to the Day Surgical Centre. It is your responsibility to check with your Health Fund if this applies to your admission.** | | | | | |
| **Fees: WORKERS COMPENSATION/THIRD PARTY – I understand that payment of my account, in full, is my responsibility and that my insurer/solicitor/health fund may not cover the total amount invoiced. If my insurance company, solicitor or health fund has not paid my account within 90 days I understand that I am required to pay all outstanding monies immediately. I accept that if my claim is unsuccessful, I will be responsible for all outstanding accounts relating to treatment received by me. I am responsible for any further costs that might be incurred resulting from not paying my account, in full, by the due date i.e. interest, debt recovery fees.**  **APPOINTMENT CANCELLATION POLICY AGREEMENT:**  Capital Pain and Rehabilitation Clinic is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, another patient is not given the opportunity to be seen.  **Please call us on 02 6282 6240 by 2pm on the day prior to your scheduled appointment** to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 2pm on *Friday*. If prior notification is not given, you will be charged $50.00 for Therapists and $100.00 for Doctors for the missed appointment. The cancellation fee will only be waived upon presentation of a medical certificate.**  **I have read, understood and agreed to the details outlined above.** | | | | | |
| ***SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_***  ***We accept VISA, MasterCard, EFTPOS and personal cheque or cash in the rooms*** | | | | | |
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