# CAPITAL PAIN & REHABILITATION CLINIC

**25 NAPIER CLOSE**
**DEAKIN ACT 2600**

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

## PERSONAL DETAILS

Dr/Mr/Mrs/Ms/Miss/Master/(Military)Rank: ________ Date of Birth: ___/___/_____

Sex: Male ☐ Female ☐ Not Specified ☐

First Names: ______________________________ Surname: _______________________

Address: _________________________________ Home Phone: ____________________
_________________________________ Work Phone: ____________________
Mobile Phone: ____________________
Can we send you SMS reminder of appointments? Y / N

Email: _________________________________

Next of Kin (name): ________________________ Contact Phone Number: ____________________

Relationship to you: ________________________

Referring Doctor: __________________________ GP (if different): __________________

**Medicare and Health Fund Details**

**Medicare Card Number**: __________________ Position: __ Expiry Date: _ _ / _ _

**Private Health Fund**: ______________________ Member Number: ________________

Level of Cover (*please circle one option*): BASIC / BRONZE / SILVER / GOLD / DIAMOND

**How did you hear about us?** ________________

## DVA / MILITARY

**DVA**

DVA Number: ________________

DVA Card Colour (*please circle one*): WHITE / GOLD

***White Card Holder:***
Accepted Condition: ________________________
__________________________________________

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**MILITARY**

PMKEYS: _______________
DAN: ____________

## Workers Compensation/Third Party

Insurance Company: _______________________
Phone: _______________Fax: _______________

Claim Number: ___________________________
Date of Accident: ___/___/____

Rehab Provider: __________________________
Phone: ______________Fax: ________________

Solicitor _________________________________
Phone: ______________Fax: ________________

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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**:

**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***