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| PERSONAL DETAILS  |  |  |  |  | | --- | --- | --- | --- | | **Title (please circle):**  Dr Mr Mrs Miss Ms Other: | |  | | | Surname: | First Name: | | Middle name: | |  |   Street Address and suburb:   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Mobile: | Home Phone: | | Work Phone: | | | **Date of Birth: / / Email address:** | | | | | **Medicare Number:**   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |   Reference No.: Expiry: \_\_\_\_ / \_\_\_\_\_ | | Logo  Description automatically generated **Department of Veterans Affairs**  DVA No.: Expiry:  Gold / White / Orange (please circle) | | | **Private Health Insurance: YES / NO**  **(PLEASE CIRCLE)**  Fund Name:  Member No.: | | **Local GP Name:**  **Clinic Address:**  **Telephone:** | |  nEXT OF kIN  |  |  |  | | --- | --- | --- | | Name: | Relationship to patient: | Telephone: |  DECLARATION  |  |  | | --- | --- | | **CONDITIONS OF TREATMENT:** Payment is required on the day of consultation. Should payment not be made on the day, I acknowledge I will pay any additional account fees and charges that may be incurred until account is paid in full. In the event of non-payment, I consent to my details being referred to a debt collecting agency and / or law firm, and I understand that I will be liable for all costs incurred, including legal demand costs. I understand it is my responsibility to ensure my referral is current.  **PRIVACY PATIENT INFORMATION:** To provide a high standard of medical care, we need to collect personal information from our patients. This information is usually collected from the patient but may be collected from family members and other health care providers with the patient’s consent. At times, some of this information needs to be shared with other health care providers or we may be legally bound to disclose personal information. All persons accessing your personal health information are bound by confidentiality. For more information, please read our [Privacy Policy](https://sleepandlungcare.com.au/privacy-policy/) or request a copy. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your doctor. | | | I have read, understood, and agree to this practices’ policy regarding the conditions of treatment and the collection, use and disclosure of medical information. | | | Signature of patient/guardian: | Date: | | Print Name: | | | **YES NO I consent to having my consult summaries uploaded to My Health Record** | | |

# ***PLEASE TURN OVER AND COMPLETE BACK PAGE* PAGE 1**

**CONSENT TO REQUEST/RELEASE INFORMATION:**

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While managing your health we may need to collect your past results or investigations to provide a high standard of care.

This information is usually collected from the patient, but occasionally may need to be collected from family members and other health care providers, *with the patient’s consent*.

At times we may also need to disclose your information to other health care providers, or be legally bound to disclose personal information.

I (full name), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

hereby consent to Sleep and Lung Care to collect reports, clinical notes, or relevant investigations which contain my personal and health information from any health professional, hospital, or other health institution for the purpose of assisting with my medical treatment.

I understand that all personnel at *Sleep and Lung Care* are bound by strict confidentiality agreements.

For more information about how we handle your personal information, please read our [Privacy Policy](https://sleepandlungcare.com.au/privacy-policy/) or request a copy.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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