VICTORIAN HAND SURGERY ASSOCIATES:

☐ **Mr Will Alexander** ☐ **Mr Anthony Berger** ☐ **Mr Timothy Bennett** ☐ **Mr Damian Ireland**
☐ **Mr Peter Maloney** ☐ **Mr David McCombe** ☐ **Mr Stephen Tham** ☐ **Mr James Thomas**

Mr / Mrs/ Mx / Ms / Miss / Master/ Dr (please circle)
(Surname)…….…… **(First Name)** ……..……

Date of Birth: ……/……/…….. **Age:** …….. **Occupation**: ……...

Address:……**P'code:**…….

Phone: (Home): …… **(Business):** ..…… **(Mobile):** ……..

Email address:.....

Next of Kin:……**Relationship:**……**Contact No:**……

Medicare No: ☐☐☐☐☐☐☐☐☐☐ - Ref' No: ☐ (Number in front of name) Expiry: ___/ _____

Person responsible for account: Self ☐ Workcover ☐ TAC ☐ Veterans Affairs ☐ Defence ☐

Parent / Guardian (if patient under 18yrs):……DOB___/___/___/.....M'care ref No.....

Private Hospital Insurance: **Yes** ☐ **No** ☐ If yes, member for 12 months or more? **Yes** ☐ **No** ☐

Name of Fund:……M'ship No:……...

DVA Card Number:……..Gold ☐ White ☐

Referring Doctor: ……

Name and address of GP (if other than above): ……..

WORKCOVER – (complete only if a work related accident)

Employer: …….. Phone No…….

Address:……..

Accident date: …… Insurance Agent: ……..…….. Claim No:…….……...

Case Manager……..Email Address:…….....

TRANSPORT ACCIDENT COMMISSION - (complete only if a TAC claim)

Date of accident:..... Claim No:.....

GENERAL HEALTH HISTORY

Do you suffer from any serious illnesses? ……..
Please indicate (tick) if you have a history of the following:
High blood pressure: ☐ Heart disease: ☐ Hepatitis C: ☐ Bleeding tendency: ☐
Blood clots: ☐ Diabetes: ☐ Epilepsy: ☐ HIV: ☐

Are you taking any 'blood thinning' medication? If so, which one?.....
List any other current medications……
……..
Do you have any allergies to medication or other products? ie latex, tapes **Yes** ☐ **No** ☐
If yes, give details…….

Do you agree to letters being sent to your referring doctor or other health professionals involved in your care?
Yes ☐ **No** ☐

Photography: A photographic record is made of some cases and used for educational purposes or scientific publications. They are stored securely and kept anonymous. **Do you agree to photographs being taken?**
Yes ☐ **No** ☐

Privacy Policy: The confidentiality of your personal details and medical history will be strictly maintained. A copy of the privacy policy is available on request.

SETTLEMENT OF ACCOUNT:

A copy of the terms of contract for settlement of your account/s is displayed at the reception desk and is also available upon request.

I HAVE READ AND AGREE TO THESE TERMS

Signature…….DATE:……..

VICTORIAN HAND SURGERY ASSOCIATES

(An association of independent specialist surgeons)

Health Information Collection and Use Consent Form

As a patient of our 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 and secure storage of your health information. 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 personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual health care. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements eg notifiable diseases.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my 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.	
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	

Patients Name_____
Date_____/_____/_____
Patient's signature_____
Signed as Guardian for child_____
Name (printed) _____