DR DAVID MILLAR
Dr Yin Min Hew
Nick Fonceca

SEXUAL HEALTH SPECIALIST

PATIENT INFORMATION

Title: ______ Surname: _________________________ Given Name/s: ___________________________

Date of birth: _________________________ Occupation: _____________________________________

Residential Address: ____

___________________________ Suburb: ______________________ Postcode: ____________________

Preferred Postal Address (If different from above): ____

___________________________ Suburb: ______________________ Postcode: ____________________

Work ph.: __________________ Home ph.: ___________________ Mobile: ______________________

Email address (please only provide email if it can be used by this practice when necessary):

____

Preferred contact method: ____

Partners name (optional): ____

Authorised contact ([optional] person who is authorised to discuss appointment details etc. on your behalf): ______________________________________Relationship: ______________________________

MEDICARE/DVA CARD DETAILS

Medicare no. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref: __ Exp. date: ___ ___/___ ___ ___ ___

Does Medicare have your bank details? Yes/No

Dept. of Veterans Affairs Number: ________________________ Card colour: _____________________

DOCTOR DETAILS

Referring Drs Name: _____________________________________ Suburb: ________________________

Usual GP Name (please only provide details if you give permission for your GP to receive a copy of appointment details etc.):

____ Suburb: _______________________

Perth Men's Health is a private billing practice. Payment is required at the time of consultation for all patients and most services include a Medicare rebate which can be processed at the time of payment. Please do not hesitate to discuss fees/Medicare rebates with our reception staff.

Perth Men's Health

CONSENT FORM

It is the policy of this practice to ensure the confidentiality and security of the personal and health information of those attending. It is also the policy of the practice to abide by the requirements of the *Privacy (Private Sector) Amendment Act 2000.*

It is necessary to collect personal information from you for the primary purpose of assisting the development of diagnosis, treatment and further advice concerning a particular health condition, suspected health condition or circumstance relating to health. The personal and health information collected will be used in the following areas;

1. Administrative purposes in running the medical practice.
2. Billing purposes, including compliance with the Health Insurance Commission and Department of Veterans' Affairs requirements.
3. Disclosure to others involved in your health care (including treating doctors, specialists and other healthcare professionals outside this medical practice). This may occur through referral to other doctors, referral for medical tests and in the reports or results returned to this practice following referrals.
4. Disclosure to medical staff of the hospitals where this will be of importance in the furtherance of your health care.
5. Disclosure for research and quality assurance activities to improve individual and community practice.
6. Disclosure to legal and insurance enquiries where such evaluations and information is required for the proper conduct, elucidation and compensation of the matter in hand.

I have read the information provided above and understand the reasons my personal and health information is required to be collected. I am also aware that this practice has a Privacy Policy pertaining to the handling of personal health information of its patients.

I understand that I am not obliged to provide any information requested of me, but that failure to do so might compromise my health care, treatment of – where applicable – the proper evaluation of my disability.

I am aware of my right to access the personal and health information collected, except in some circumstances where access might legitimately be withheld. I understand that if my personal and health information is to be used for any other purpose other than set out above, my further consent will be obtained (unless otherwise ordered by a court of law.)

I consent to the handling of my personal health information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify to this practice.

NAME

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SIGNED ____ **DATE**: _______________________