DR DAVID MILLAR
Dr Yin Min Hew
Nick Fonceca

SEXUAL HEALTH SPECIALIST

Perth Men's Health

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: ___ ___/___ ___ ___ ___

Dept. of Veterans Affairs Number: _____ Card colour: _____

How did you hear about us? ☐ Website ☐ Facebook ☐ Advert ☐ Word of mouth ☐ Doctor's referral

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. This practice abides by the requirements of the *Privacy Act 1988 and the Australian Privacy Principles outlined within Schedule 1 of that Act.*

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 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 and that I may request a copy of this Policy at any time, or download this from the website www.perthmenshealth.com.au .

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 where applicable and/or 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).

This practice is registered for My Health Record and as such our Healthcare providers can download, with your consent, and use relevant health information about you which may assist in your treatment. The Healthcare providers within the practice, may also upload relevant information regarding your treatment such as referrals, event summaries, prescriptions, specialist letters which may assist in your health care and will do this from time to time, when a new treatment course is commenced. I understand that my consent, under a separate form will be sought prior to using My Health Record. I also understand that I can withdraw consent in writing at any time to the use of My Health Record in relation to my medical information.

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 _____

SIGNED I have read and agree with the Consent Form conditions. (Tick box for YES) _____ ☐ **DATE**: _____