PATIENT INFORMATION AND CONSENT FORM

TITLE Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Master ■ Dr ☐

D.O.B. **EMAIL:**

SURNAME **PREV. SURNAME** If applicable

FIRST NAME **MIDDLE NAME(S)**

RESIDENTIAL ADDRESS

SUBURB **POSTCODE**

POSTAL ADDRESS If different to residential address

TEL. No. (HOME) **(WORK)** **(MOBILE)**

MEDICARE No. **Ref. No (next to your name)** **Exp.**

DEPT. VETERANS AFFAIRS No. **Gold** ☐ or **White** ☐ **Exp.**

GUARDIAN DETAILS (must be completed if patient under 18)

NAME

POSTAL ADDRESS If different to patient's address

RELATIONSHIP TO PATIENT

D.O.B.

Account Information

Albany Imaging is a private practice which bulk bills where possible with a valid Medicare card. For patients without a Medicare or DVA card there will be fees for our services, which will have to be paid at the time of your appointment. As a private practice there may be fees associated with some procedures, for which if you are entitled to a Medicare rebate which can be processed on the day of your appointment. We encourage you to ask about the costs of your procedure at the time of booking your appointment. By signing this form, you are acknowledging our account terms.

Privacy Information

Albany Imaging is committed to protecting the privacy of our patients and complies with the Privacy Act (1988). We collect, use, store and disclose your personal information:

- To complete the examination or procedure you have requested us to perform;
- To make information available to your referrer and/or other health care providers involved in your medical management via our secure information systems;
- To manage our practice, including billing and collection of accounts; and
- As permitted or required by law.

Your specific consent will be obtained prior to any trans-border image transfer. If we cannot collect, use and disclose your personal information, we may not be able to provide our services to you. Privacy requests should be discussed with our staff. Certain requests may reduce the efficiency of the health care services provided. By signing below, the patient/legal guardian confirms that they:

- Have read and understood the information provided above;
- Have requested further information if required;
- Have discussed specific privacy requests with staff; and
- Consent to Albany Imaging indefinitely collecting, using, disclosing and otherwise handling their personal information in the manner described above, unless otherwise discussed with and agreed to by our staff.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

Date

Additional Copies of Report to be sent to: (please note reports can only be sent to Health Care providers)

NAME **PRACTICE**

PHONE No. **FAX No.**