YSC Spine Ortho Clinic

Mr John Y S Choi
MBChB FRACS (Ortho)
Spine & Orthopaedic Surgeon

PATIENT DETAILS

Title | Surname

First Names | Preferred Name

Address

Suburb | Postcode | Date of Birth (- -)

Home Tel. | Work Tel. | Mobile

Email

Please tick here if you do not want to receive SMS or Email messages for appointment reminders ☐

Occupation | Part of Body Injured

Medicare No | Patient Reference No. | Expiry Date (-)

NEXT OF KIN

Relationship

Telephone Numbers

PRIVATE HEALTH INSURANCE

Do you have private health insurance for a private hospital ☐ YES ☐ NO

Name of Fund: | Membership No.

VETERANS AFFAIRS

☐ | File No | Colour of Card:

PENSION CARD

☐ | File No | Expiry Date (-)

HEALTH CARE CARD

☐ | File No | Expiry Date (-)

REFERRING DOCTOR

Address

LOCAL DOCTOR

Address

OTHER

PLEASE COMPLETE OTHER SIDE & SIGN WHERE INDICATED

TRANSPORT ACCIDENT ✓ Claim No

Has the patient paid initial medical expenses levy ☐ YES ☐ NO Date of Injury - -

WORKCOVER ✓ Claim No Part of Body Injured

Employer

Address

Claims Officer (Name, Tel & Fax)

Insurance Company Date of Injury - -

SIGNIFICANT MEDICAL HISTORY

☐ Diabetic ☐ High Blood Pressure ☐ Heart Disease

☐ Do you take Aspirin or Blood Thinners (please specify)

☐ Gastric Lap Band ☐ Pacemaker (please specify type and when inserted)

☐ Other Significant Medical History (please specify)

ALLERGIES

☐ Please specify

PAYMENT TERMS

- CONSULTATIONS: Payment is expected at the time of consultation.
- NON-ATTENDANCE: If 48 hours is not given for cancellation of an appointment a $50 fee applies.
- SURGERY: Payment of the full fee/gap/out of pocket fee (as quoted in the Informed Financial Consent which will be provided) will be payable ten days prior to surgery.
- In the event an overdue account is referred to a collection agency and/or law firm, you will be liable for all costs which would be incurred as if the debt is collected in full, including legal demand costs.
- Overdue accounts will be subject to interest at the rate of 25% per annum, calculated for the period the account is due.
- In the event where an account is submitted to a third party, such as Workcover, TAC, Health Fund, and liability is rejected, I acknowledge that I will be liable for the full amount.

I have read the above Payment Terms and agree to abide by them.

Signature:	Date:
Please Print your Name:	
Relationship to patient (e.g. Self, Parent, Guardian)	

YSC Spine Ortho Clinic – PRIVACY CONSENT

YSC Spine Ortho Clinic collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be proactive in your healthcare needs.

Please read this form carefully, and sign where indicated below.

This means we will use the information you provide in the following ways:

- Administrative purposes in running our practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors, specialists and allied health practitioners outside this medical practice. This may occur through referral to other doctors, or for medical tests and in reports returned to us following the referral.
- Disclosure to other doctors or allied health practitioners within the practice for the purpose of continuity of patient care.
- For disclosure to visiting doctors and medical students attached to this practice for the purpose of patient care and teaching.
- Disclosure for the purpose of research and quality assurance activities to improve individual and community health care and practice management. Usually no individual names will be recorded but if this is not the case, you will be informed when such activities are being conducted and given the opportunity to 'opt out' of any involvement.
- For quality review and accreditation of the practice, medical records may need to be assessed by a visiting doctor.

I have read the information above and understand the reasons why my information must be collected. I am also aware that YSC Spine Ortho Clinic has a privacy policy on handling patient information.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given a reasonable explanation in these circumstances. I consent to the handling of my information by YSC Spine Ortho Clinic for the purposes set out above, subject to any limitations on access or disclosure that I notify in writing to YSC Spine Ortho Clinic.

There are some circumstances where information needs to be disclosed without consent ie:

- An emergency situation
- Where disclosure is necessary to lessen or prevent a serious and imminent threat to an individual's life, health or safety, or is a serious threat to public health or safety.
- Where disclosure is a legal requirement, eg a communicable disease, suspected abuse, subpoena to court
- For medical indemnity insurance

I understand that I am not obliged to provide any information requested of me but that my failure to do so might compromise the quality of health care and treatment given to me.

I consent to YSC Spine Ortho Clinic taking my photograph (which will be kept on my computer file only) for the purposes of identification and improved patient care. I understand this photograph will not be released to any other party. ☐ Yes ☐ No

I give permission for the staff of YSC Spine Ortho Clinic to call my listed home and mobile phone numbers to relay information such as appointment times. If I am unable to take the call I also give permission for YSC Spine Ortho Clinic staff to leave a message with whoever answers the phone. ☐ Yes ☐ No

Signature:	Date:
Please Print your Name:	
Relationship to patient (e.g. Self, Parent, Guardian)	