Informed Consent and Cancellation Policy

Collection of Personal information and Confidentiality:

As part of providing medical and nursing services, personal information that is relevant to your medical condition will be collected and recorded. The information is gathered for the purposes of assessment, diagnosis and treatment and is only seen by the relevant treating team. All information will be kept strictly confidential except in the following situations:

-> You are at the risk of harming yourself or another
-> It is subpoenaed by court
-> Your approval was obtained to release information to 3rd party
You may access the information recorded in the file with a written request, subject to the exceptions in the National Privacy Principle.

FEES:

Consult Length	Private Fees	Discounted Fees (Pensioner/Health CC Holder)	Medicare Rebate	Out of Pocket (For Private Fees)	Out of Pocket (For discounted rates)
Standard Consultation	$85.00	$65.00	$41.20	$43.80	$23.80
Long Consultation	$125.00	$105.00	$79.70	$45.30	$25.30
Extended Consultation	$170.00	$145.00	$117.70	$52.60	$32.60

COMMUNICATIONS CONSENT:

I consent to receive the following electronic reminders/messages via sms/email

- Appointments
- Clinical communication
- Clinical reminders
- Health awareness

CANCELLATION POLICY:

If you no longer require your appointment, please notify us as soon as possible.
This allows us to offer the appointment to another patient in need.

Non-attendance without notification within 2 hours will incur the **full-cost** of the appointment intended.

Your time and the doctor's time are equally important. Your punctuality is appreciated as it helps us to run on time. Our doctors and nurses aim to be as thorough as possible while trying to keep on schedule. Sometimes this leads to delays. We apologise for any long waiting times in advance and thank you for your patience in those circumstances.

ZERO TOLERANCE POLICY TOWARDS WORKPLACE VIOLENCE

Our staff are entitled to work in a safe and respectful environment. Verbal or physical aggression towards any of our staff members will not be tolerated. Strathmore Family Medical Centre will cease to provide any further services to the patient if this is breached. Medical records of the patient will be forwarded to another medical practice of the patient's choice.

Full Name:_____

Signature:_____

Date: / /

Patient Registration Form

First Name:_____ **Surname:**_____

Middle Name:_____ **Preferred Name:**_____

D O B: ____/____/_____ **Gender (at birth):** Male Female Other **Pronouns:** He/Him She/Her They/Them/Their

Gender Identified as: Male Female Non-binary Gender diverse Transgender Different identity

Do you identify as Aboriginal or Torres Strait Islander? Yes No **Ethnicity/Background:**_____

Address:_____ **Suburb:**_____ **Postcode:**_____

Contact Number:_____ **Mobile number:** _____

Email Address:_____

Medicare Card Number:_____ **Ref Number:**_____ **Expiry:**_____/_____

Pension or Health Care Card Number:_____ **Expiry:____/_____/_____**

Next of Kin: Name: _____ **Mobile Number:** _____**Relationship:**_____

Emergency Contact Name:_____ **Mobile Number:**_____**Relationship:**_____

Do you smoke? Yes No If Yes: How many cigarettes do you smoke a day _____

Do you drink alcohol? Yes No If Yes: How many standard drinks do you drink a week? _____

Past Medical History:

Condition	Year Diagnosed

Past Surgical History:

Procedure	Year Performed

Family History:

Family Member	Condition	Age Diagnosed

Preventative Health:

Last PAP Smear?	Last Prostate Test?
Last Breast Check?	Last Bowel Test?

Regular Medications:

_____

_____