Advanced Hand Clinic

Bhavana Jha
Physiotherapist
B. Sc. (Physio)
Accredited Hand Therapist
(as awarded by AHTA)

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New Patient Details Record (Please ask us if you are not sure what something means)

Section A

Title: Dr Mr Master Mrs Ms Miss

First name: …… Preferred Name: ……

Surname: …… Middle name: ……

Date of birth: ……/……/…… Mobile ph: ……

Work ph: …… Home ph: ……

Next of Kin: …… Next of Kin Phone: ……

Address: …… P/code: ……

Email: ……

Send me SMS appointment reminders: Yes ☐ No ☐

Section B

GP: Name: …… GP's Practice Name: ……

Referrer: *(if not referred via GP)* ……

Medical Information:

Relevant medical conditions: ……

Allergies: …… Pacemaker: Yes ☐ No ☐

Do you have private health cover? Yes ☐ No ☐

Health Fund: …… Number: ……

Are you a veteran's affair patient? Yes ☐ No ☐

DVA No: …… Expiry: ……. / …… Card: White☐ Gold☐

Are you on an extended care plan (EPC or CDM) from your doctor? Yes ☐ No ☐

Is this a Third party claim? Yes ☐ No ☐ (*i.e. is someone else like an insurance company paying for you?)*

Is this a WorkCover claim? Yes ☐ No ☐

Date of accident/injury: …… Claim No: ……

Name of Case Manager: …… Contact details: ……

Privacy Information and Consent Form

PLEASE READ THIS INFORMATION AND SIGN AND DATE THE BOTTOM OF THE PAGE

PRIVACY INFORMATION

Advanced Hand Clinic (AHC) recognises the importance of keeping your Personal Health Information (PHI) that you entrust to us, confidential and protected. If you require further information regarding this privacy statement, AHC has a written privacy policy that reflects the Federal Privacy Act 1988 (and amended Privacy Act 2000). As a patient of **AHC**, certain PHI will be required to establish and maintain your treatment plan.

Collection Of Information: AHC will only collect necessary PHI which is required for assessment and treatment. This may include, but is not limited to: full medical history, family medical history, contact details, Medicare and private health fund details, billing & account details. There are instances where **AHC** may need to collect information from outside sources such as other medical practitioners, allied health professionals, and where applicable, a hospital. **AHC** therapists and administrative staff may be involved in the information collection.

Use And Disclosure: With your consent, **AHC** will use and disclose your information for reasons such as provision of advice of treatment and communication with your referrers and health care team; onward referral to other medical or health care services. AHC will also use your information for account keeping purposes.

Access: It is within your right at any time to request access to your PHI and records. This can be done via a request form. **AHC** can provide a soft or hard copy, however AHC does retain the right to refuse if the information requested poses a health and safety concern, threat or injury; impacts the privacy of other individuals and/or impacts a legal proceeding or court order.

CONSENT

By signing the form below, I give consent for **AHC** to collect, use and disclose my personal information as outlined above. I authorise **AHC** to obtain either verbal or written information in relation to my therapy from the following agencies: doctor and treating surgeon, insurance company, case manager, referrer and employer.

I authorise **AHC** to release information concerning relevant aspects of my therapy program and discuss that information with representatives of the agencies included in my health care.
If there are specific people you do not want us to communicate to, please list here: ……..……..

I consent to undertake assessment and treatment provided by the staff of **AHC.** I understand I have a right to decline part or all of the treatment being offered. I accept that I have to take personal responsibility for my rehabilitation and to actively participate in the treatment plan developed.

I will pay any costs associated with my treatment or that of my dependant (including splinting &/or other consumables) that the therapist will discuss with me during the treatment session (unless they are covered by WCQ or other insurer).

With this consent, **AHC** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO (treatment, payment, & operations), such as appointment reminders, insurance items and any information pertaining to my clinical care.

I understand that, if any debt collection services are engaged to retrieve any outstanding accounts relating to my hand therapy, I will need to pay the fees associated with this.

I also understand it is my responsibility as a patient to attend all scheduled appointments, and that I will need to contact **AHC** to reschedule an appointment I have cancelled or did not attend.

By signing this form, I declare this information to be true and correct and that I have not withheld any information.

Patient name: …….. **Date:** ……

Signature of Patient (Parent/Guardian if under 18 years): ……..

Name of parent/guardian if patient is under 18 years: ……..