# Privacy Statement & Consent

**I** _____, DOB: ___/___/_____, understand that Mead Medical complies with the Privacy Act (1988) and the Privacy Amendment Act 2000 and as part of their Privacy Policy they are committed to protecting the privacy of the personal information of individuals. The purpose of collecting my personal details is to provide quality medical and health services and related account keeping. I understand that I have the right to request access to my information. Mead Medical makes every effort to keep my data in accordance with the National Privacy Principles and keep my records accurate and up to date. I understand that I may withdraw my consent for Mead Medical to use and disclose my personal information (except where legal obligations are met)

**Collection, Use & Disclosure**
We recognize that the information we collect is often of a highly sensitive nature and as an organization we have adopted the highest privacy compliance standards relevant to ensure personal information is protected.
We are a service company to the medical practitioners who provide services at our practice. For administrative and billing purposes, and to enable the patient to be attended by other practitioners in our practice, patient information is shared between the practitioners who attend a patient. We (on behalf of) and the practitioners may collect personal information (including health information) regarding patients for the purpose of providing medical services and treatments to patients. Personal information collected will generally include, the patients name, address, telephone number, and Medicare number, health care fund, current drugs or treatments used by the patient, previous and current medical history, including where clinically relevant a family medical history, and the name of any health service provider or medical specialist to whom the patient is referred, copies of any letters of referrals and copies of any reports back.

We will not share your personal information with anyone outside Australia (unless under exceptional circumstances that are permitted by law) without your consent.

**By signing below, I the patient (or the parent/legal guardian of the patient) have read and consent to the above and acknowledge that personal information collected by us may be used or disclosed:**

- Mead Medical will be collecting, using, storing and disposing of my personal information
- The release of relevant personal information to other health professionals to allow quality medical care e.g. specialists, pathologists, usual GP, some fees may be incurred for transfer of records
- During the course of providing medical services, through eTP, My Health Record (eg Shared Health Summary, Event Summary)
- I acknowledge that any additional visits to external service providers such as pathology, specialists, imaging etc may incur an additional fee that is independent to the fees associated Mead Medical.
- To have my records reviewed by an Accreditation Surveyor as part of this practices accreditation process should my records be randomly chosen for quality assurance, for training, billing, liaising with government offices regarding Medicare entitlements and payments and as may be required by our insurers.
- DE identified data collection for research and population health planning purpose
- The release of relevant personal information to my employer/prospective employer, their authorised representative and their insurer in the case of a work related consultation of service.
- Mead Medical will use your mobile phone number and email address for the purpose of SMS/email recall/reminder and health related systems.
- Mead Medical will collect information necessary for your treatment. This may include Full Medical and Psychological History;
- where there is a serious and imminent threat to an individual's life, health, or safety, or a serious threat to a public health or public safety or as required under compulsion or law
- consent my treating GP to bill Medicare for appropriate MBS item number in relation to my consultation/s and or treatment/care

**We may access information:**
- provided directly by the patient
- provided on a patient's behalf with the patient's consent
- from a health service provider who refers the patient to medical practitioners,
- from health service providers to whom patients are referred

**Other than as described in the Policy or permitted under the National Privacy Act, Mead Medical Practice uses its reasonable endeavour's to ensure that identifying health information is not disclosed to any person.**

**Signed:** _____ **Dated:** _____

**Witness to signature:** _____ **Dated:** _____

# Patient Registration & Consent

**Please print clearly & fill in all relevant information.**

**Patient Details**

Title:_____
Family Name: _____
Given Name: _____
Middle Name: _____
Preferred Name:_____
Date of Birth:_____
Sex:_____

Street No & Name: _____
Suburb: _____Postcode:_____
Home No: _____ ☐
Work No: _____ ☐
Mobile No: _____☐
Email: _____☐
***(Please indicate your preferred method of contact above)***

**Ethnicity – What is your predominant heritage?**

Australian, non-indigenous ☐
Aboriginal but not Torres Strait Islander ☐
Torres Strait Islander but not Aboriginal ☐
Both Aboriginal and Torres Strait Islander ☐
Not provided ☐
Other:_____
Religion:_____

Medicare No: _____
Ref: _____
Expiry Date: _____

Pension Card No: _____
Expiry Date: _____

Health Care Card No: _____
Expiry Date: _____

DVA No: _____
Type:_____

**Occupation**: _____

**Next of Kin:**

First Name: _____
Last Name: _____
Address:_____
Contact No:_____
Relationship:_____

**Second Emergency Contact:**

First Name: _____
Last Name: _____
Address: _____
Contact No:_____
Relationship:_____

**Legal Guardianship/Power of Attorney in place: Y / N**

First Name: _____
Last Name: _____
Address:_____
Contact No:_____
Email: _____
Copy of legal guardianship provided? **Y / N**

**My Health Record:** Are you registered? **Y / N**

**Allergies? Y ☐ or N ☐**
**Please List:**_____
_____
_____

***SMS IS ROUTINELY USED BY OUR PRACTICE, YOU WILL NEED TO NOTIFY STAFF IF YOU DO NOT WISH TO RECEIVE SMS.***

Mead Medical use SMS for Appointment Reminders, Recalls, Health Awareness, Results & Clinical messages.

## HEALTH & OTHER INFORMATION

**Children: Y** □ or **N** □ How many? _____ Age/s: _____

**Life Style History**
Height: _____cm Weight: _____kg Blood Group: _____

**Current Alcohol Intake** - Drinker? Y □ or N □
If Yes, Number of Days per week? _____
Occasional □ Moderate □ Heavy □
Number of standards drinks per day? _____
Have you ever felt you ought to cut down? Y □ or N □
**Ex-drinker?** Y □ or N □

**Current smoking history** –
Non-smoker □
Ex-Smoker □ Year started? _____ Year stopped? ____ Quantity? _____per day
Smoker □ Year started? _____ Quantity? _____per day
Would you like advice/support to quit smoking? Y □ or N □

**Current Medications** (including over the counter medications, vitamins & minerals):
_____
_____

**Your Health History:**
□ Asthma/Lung Disease □ Diabetes? □ Hypertension? □ Heart disease? □ Stroke? □ Mental Illness? □ Operations? _____

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Other?_____

**Females**
When did you have your last Cervical Screening Test? Date:_____ Not sure: ___ Never: ___
When did you have your last Mammogram? Date:_____ Not sure: ___ Never: ___

**Males**
When did you have your last Prostate Exam? Date:_____ Not sure: ___ Never: ___

**Immunisations**
Tetanus Booster Date:_____ Pneumococcal Date:_____
Childhood Vaccines up to date? □ Yes □ No

**Family History**

**Mother:**
□ Asthma/Lung Disease □ Diabetes? □ Hypertension? □ Heart disease? □ Stroke? □ Colon cancer? □ Mental Illness? □ Breast Cancer? □ Other? _____

**Father:**
□ Asthma/Lung Disease □ Diabetes? □ Hypertension? □ Heart disease? □ Stroke? □ Colon cancer? □ Mental Illness? □ Prostate Cancer? □ Other? _____

**Any other significant family history?** Y □ or N □
Comment: _____
_____