Orthopaedic Surgery Institute of WA

Patient Registration Details

Surname: _____

Christian Name: _____ **Middle Name:** _____

Preferred Name: _____

Home Address: Number / Street _____

Suburb _____ Postcode _____

Mailing Address: PO Box _____

Suburb _____ Postcode _____

Phone Numbers: Home _____ Mobile _____

Email _____

Date of Birth: ____ / ____ / 19____ or ____ / ____ / 20____

Occupation: _____ **Business name:** _____

Work No: _____ **Address:** _____

Marital Status: **0 Married** **0 Single** **0 Widow** **0 Divorced** **0 Separated** **0 Defacto**

Spouse / Partner: _____

Contact Numbers: Home _____ Mobile _____

Contact Person – close friend/relative (not living with you) _____

Contact No. _____

Address: Number / Street _____

Suburb _____ Postcode _____

Medicare No. _____ **Reference No.** _____ **Expiry** ____ /____

Age Pension No. _____ **Health Care Card No.** _____

Private Health Fund: _____ **Table** _____ **Private Fund No.** _____

Family Doctor & Address: _____

Referring Doctor: _____ **Date of Referral** ____ / ____ / 20____

Who is responsible for paying your account?

(Self, parent, solicitor) Full Name _____

Street Address _____

Suburb _____ Postcode _____

If your attendance is related to a Workers' Compensation Claim or a Motor Vehicle Accident:

Employer. _____ Claim No. _____

Insurer. _____ Claim No. _____

Place of accident/injury _____ Date of accident/injury ____ / ____ /____

I understand that from these rooms Mr. Ian Skinner, Mr. Robert Petanceski and Mr. Vara Mukundala carry out private practice in Orthopaedic Surgery and that this practice does not bulk bill. I accept that consultations are to be paid in full at the time of the visit unless this visit is related to an accepted 3rd party motor vehicle insurance claim, the details of which are provided above. In the event of a 3rd party claim being refused by the relevant authority, I will accept responsibility for payment of any account for professional services given. I understand, that any expenses, costs or disbursements incurred by this practice in recovering any outstanding monies will be repaid by myself.

Signed: _____ **Date:** ____ / ____ / 20____

If you do not understand this, please discuss with the secretary before your consultation.

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incorporating ... hipandknee

Ian J Skinner
MBBS, FRACS (Orth)
Orthopaedic Surgeon
IJ Skinner Pty Ltd
Hipandknee Centre
ABN 14 081 380 976

SHOULDER & HAND CENTRE

Robert Petanceski
MBBS, FRACS (Orth), AOA
Orthopaedic Surgeon
R Petanceski Pty Ltd
Shoulder & Hand Centre
ABN 18 116 809 520

PRIVACY ACT 1988

Patient Consent to Collect & Disclose Information

The Privacy Act 1988 requires Medical Practitioners to obtain consent from their patients to collect, use and disclose that patient's personal information.

COLLECTION

This means we will collect information which is necessary to properly advise and treat you. Such necessary information may include:

- Full medical history
- Family medical history
- Ethnicity
- Contact details
- Medicare/private health fund details
- Genetic information
- Billing/account details

The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources, for example:

- Other Medical Practitioners, such as your previous doctor and any specialists.
- Other health care providers, such as physiotherapists, occupational therapists, psychologists, pharmacists, dentists, nurses and Hospitals and Day Surgery Units.

Both our practice staff and the Medical Practitioners may participate in the collection of this information. In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior consent.

USE & DISCLOSURE

With your consent, the practice staff will use and disclose your personal information for purposes including:

- Account keeping and billing processes;
- Referral to another health care provider;
- Sending of specimens, such as blood samples or pap smears for analysis;
- Referral to a hospital for treatment;
- Advice on treatment options;
- The management of our practice;
- Quality assurance, practice accreditation and complaint handling;
- To meet our obligations of notification to our medical defence, organisations or insurers;
- To prevent or lessen a serious threat to an individual's life, health or safety; and
- Where legally required to do so, such as producing records to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases.

ACCESS

You are entitled to access your own health records at any time convenient to both yourself and the practice. Access can be denied where:

- To provide access would create a serious threat to life or health;
- There is a legal impediment to access;
- The access would unreasonably impact on the privacy of another;
- Your request is frivolous;
- The information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings; and
- In the interests of national security.

We ask that, where possible, your request be in writing. We may impose a charge for photocopying or for staff time involved in processing your request. Where you dispute the accuracy of the information we have recorded, you are entitled to correct that information. It is our practice policy that we take all steps to record all your corrections and place them with your file, but will not erase the original record.

CONSENT

I provide my consent for Mr. I.J. Skinner / Mr. R. Petanceski / Mr. V. Mukundala(Orthopaedic Surgeon) to collect, use and disclose my personal information as outlined above.

I understand that I am entitled to access my own health records except where access would be denied as outlined above.

I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).

PATIENT NAME: _____

SIGNED: _____

WITNESSED: _____

DATE: _____/_____/ 20_____

AUTHORISATION TO PROVIDE RECORDS/RESULTS

We may need to collect relevant information regarding you from various pathology laboratories, radiology facilities, or from other doctors, specialists, or other health care providers. This authorisation will allow us to collect this information.

I _____

Of _____

herebyauthorise the provision of relevant medical records and/or test/investigation results to Mr. I.J. Skinner / Mr. R. Petanceski / Mr. V. Mukundala(Orthopaedic Surgeon), Orthopaedic Surgery Institue of W.A., 100 Murdoch Drive, Murdoch WA 6150.

SIGNED: _____

WITNESSED: _____

DATE: _____/_____/ 20_____

Phone: 9311 4800
Fax: 9311 4801