MR GEORGE T. WONG, *F.R.A.C.S.* **&** ***MS SNIGDHA SAHA,*** *F.R.A.C.S*
Neurosurgeon *Neurosurgeon*

Suite 7/4 Ventnor Avenue
WEST PERTH WA 6005

Tel: 08 6275 6900
Fax: 08 62881618

PLEASE USE BLOCK LETTERS

SURNAME: Mr/Mrs/Miss/Ms _____

GIVEN NAMES: _____

ADDRESS: _____

_____ **POST CODE** _____

TELEPHONE: (Home) _____ **(Work)** _____ **(Mob)** _____

EMAIL: _____

PRIVATE HEALTH FUND (if any) _____ **M/SHIP NO** _____

DATE OF BIRTH: _____

OCCUPATION: _____

PENSION/HEALTH CARD NO: _____

MEDICARE NO: _____ **EXPIRY** _____ **REF NO** ____
(Number on left of name)

GENERAL PRACTITIONER: _____

GENERAL PRACTITIONER ADDRESS: _____

_____

NEXT OF KIN: _____

TELEPHONE: (Home) _____ **(Work)** _____ **(Mob)** _____

N.B. ALL ACCOUNTS ARE TO BE PAID IN FULL AT THE TIME OF YOUR CONSULTATION

(PLEASE NOTE WE DO NOT ACCEPT AMEX)

****IF WORKERS COMPENSATION – MOTOR VEHICLE – PUBLIC LIABILITY****

PLEASE COMPLETE THE FOLLOWING DETAILS:

EMPLOYER: _____

INSURANCE COMPANY: _____

CLAIM NO: _____ **DATE OF INJURY:** _____

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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 that 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

This 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 former G.P.s and Specialists
- Other health care providers, such as Physiotherapists, Occupational Therapists, Psychologists, Pharmacists, Dentists and Nurses
- Hospitals and Day Surgery Units

Both my practice staff and I 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 express consent.

USE & DISCLOSURE

With your consent, the practice staff will use and disclose your information for purposes such as:

- Account keeping, billing and debt collection purposes
- Referral to another medical practitioner or health care provider
- Sending of specimens such as blood samples, for analysis
- Referral to a hospital for treatment and/or advice
- 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
- Where legally required to do so such as producing records to court, mandatory report 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 success 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
- In the interest 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 will take all steps to record all of you corrections and place them with your file but will not erase the original record.

CONSENT

I provide my consent for Mr. George Wong/Ms Snigdha Saha and his/her staff 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).

Patients name (Please print): _____

SIGNED: _____

WITNESSED: _____

DATE: _____