MP Sports Physicians
Specialists in sport and exercise medicine

PATIENT REGISTRATION SHEET

How did you hear about MP Sports Physicians? (Please circle)

GP **Su**rgeon **Sp**ecialist **Ph**ysio **My**o **Ma**ssage **Po**diatrist

Family **Fr**iend **We**bsite **Os**teo **Ch**iro **Fo**oty

Surname (Ms Mrs Mr Dr Other)……

Given Name (Medicare card name)……

Date of Birth …… Occupation ……

Address ……

…… Postcode ……

Telephone (Home) …… (Work) ……

(Mobile) …… MIA id number……

Email **(please print clearly)** ……

We DO NOT send advertising material or pass on your details to any third party. Please tick if you DO NOT want to receive educational articles and sports medicine updates via email ☐

Medicare Number __ __ __ __ __ __ __ __ __ __ Patient no. on card __

Medicare Expiry Date __ __ / __ __

Private Health Fund ……

Pension Number …… Expiry……

Allergies <None Known> <Allergic to>……

Next Of Kin **(compulsory)** …… Relationship……Ph……

Referring Practitioner …… (Tel……)

General Practitioner ……

(Address)……

…… (Tel……)

Payment is expected on the day of consultation in all cases.

Rebates can be claimed from Medicare, but there will be a gap between the rebate and the fee charged. ***Workcover and TAC patients are also expected to pay up front and claim back from their insurer. There may still be an out of pocket cost*.** Please ask at reception if you require further information.
If for any reason an account remains outstanding, it will be passed to the debt collectors without further notice. The patient will be responsible for any associated collection fees.

I HAVE ALSO READ AND UNDERSTAND THE PRIVACY LEGISLATION CONSENT FORM ON THE REVERSE SIDE.
***If required, I consent to my consultations being performed as telehealth consultations.*

Patient's Signature…… Date……

Signature of Parent or Guardian if patient under 16 ……

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PRIVACY LEGISLATION CONSENT FORM

We require your consent to collect information about you. Please read this information carefully and sign the bottom of the form where indicated.

Your treating practitioner at MP Sports Physicians collects information from you to enable us to provide quality medical care. Your personal details and full medical history allow us to properly assess, diagnose and treat you in a timely and proactive fashion. This means the information you provide us may be used in the following ways:

- Administration purposes in running this medical business
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosures to others involved in your health care, including treating doctors and allied health providers outside of this practice. This may occur through correspondence to your referring practitioner, referral to other doctors or allied health practitioners, or referral for medical tests. It may also occur in the return of reports or results returned to this practice following these referrals.

……...

I have read the above information and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on the handling of patient information.

I understand that I do not have to provide any information requested of me, but that failure to do so may compromise the quality of health care I receive.

I am aware of my right to access the information collected about me except in some circumstances where the information may be legitimately legally withheld. I understand I will be given an explanation in these circumstances.

I understand that my further consent will be requested if my information is to be used for any purpose other than those stated above.

I consent to the handling of my information by this practice for the purposes stated above, subject to any limitations on access or disclosure that I notify this practice of.

Thank you for taking the time to read and sign our patient registration form.