**PATIENT INFORMATION**

**Please check and complete the following details:**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | **Title:** <title> | **NHI:** <NHI> | | **First Names:** <firstnames> | **Known As:** <knownas> | | **Last Name:** <lastname> | **Date of Birth:** <dob> | | **Home Phone:** <homephone> | **Work Phone:** <workphone> | | **Mobile Phone:** <MobPhone> | **Opt-In to SMS:** Yes / No | |
| **Email:**  <Email>  **Physical Address:** <address(1-2)>,<address(3-5)>  **Billing Address** (*if different from above*):  **Correspondence Address** (*if different from above):*  **Other Contacts:** |
| **GP:** <gp>  **Referring Dr** (*if different from above):* <ref. dr.>  **Occupation:** <occupation>  **Insurance Company:** <PatIns>  **ACC:** Yes / No |
| **Medication:**  **Allergies:**  **Do you take aspirin or any other tablets to thin your blood?:**  **Have you been admitted to any hospital (in NZ or overseas) in the past twelve months:** Yes / No |

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| PRIVACY STATEMENT  We are committed to providing quality healthcare for our patients. As a fundamental part of this commitment, we recognise the importance of ensuring that our patients are fully informed and involved in their healthcare.  As a healthcare provider in the private sector, we are bound by the HEALTH INFORMATION PRIVACY CODE 2020. This code sets the standards by which we handle personal information collected from our patients. Further information is available online from the Office of the Privacy Commissioner  As part of our commitment to providing quality health care it is necessary for us to maintain records pertaining to your medical treatment, the provision of advice to you and also to perform administrative functions including record keeping, confirming eligibility for funding/insurance, invoicing and processing of claims/payments. If you do not provide us with the information requested we may not be able to provide you with medical treatment and advice.  Our records may contain, but is not limited to, the following types of information:   * Your Personal details (e.g. your name, address, date of birth, NHI number etc.) * Names and contact information of people who are your emergency contacts. * Your medical history * Clinical and administrative notes made during the course of consultations or treatment. * Digital images taken during your consultation or treatment * Referrals to other health service providers * Test results and reports received from or sent to other health service providers involved with your care. * Payor related details and financial transactions.   Your records are handled with the utmost respect for your privacy. They will be used by your specialist as part of providing your care. Administration and Clinical staff will also handle your medical records as part of their day-to-day responsibilities. All staff are bound by confidentiality requirements as a condition of their employment and these requirements will be observed if it is necessary for them to review your records.  Correspondence with yourself and other parties involved with your care, may use digital communication methods instead of printed material. Where possible any digital correspondence will be strongly encrypted so that the content cannot be understood if intercepted.  At times, for business-related purposes, it may also be necessary to allow external organisations to access our facility and possibly to have restricted access to your records. Any external organisation that provides services or advice to us will be aware of the need to preserve the requirement of the Privacy Act and will be bound by a confidentiality agreement.  Ordinarily we will not release the contents of your medical file without your consent. However, we advise that there may be occasions where we will be required to release the details of your file irrespective of whether your consent to the disclosure of the information is given. This will occur where the law requires disclosure, such as pursuant or subpoena.  We advise, that as a patient, you have the right of access to any information we hold concerning you and also to ask for it to be corrected if you think it is wrong. Should you wish to access this information please discuss this with your specialist.  AUTHORISATION  By signing below you agree that you:   * Have read the Privacy Statement and give permission for medical records to be kept about you and for correspondence to be sent to your referring doctor, general practitioners, other associated clinical providers, agencies and insurers, where appropriate. * Undertake to pay all fees owing to my specialist, including, in the event that liability is denied, any outstanding accounts that have not been paid in full by my insurer. * Understand that any outstanding monies requiring debt recovery will incur additional charges and you will also be responsible for any legal costs incurred.   **Patient Name:** **Signed:** |