bellarinealliedhealthgroup

CLIENT REGISTRATION FORM

Please circle Dr/ Mr / Mrs / Miss / Ms / Master

Date of birth_____

Name_____

Occupation_____

Address_____

Employer_____

_____

Referred by_____

State_____ Postcode_____

GP Name_____

Phone (M) _____

GP Address_____

(H)_____

Next of Kin_____

(W)_____

Next of Kin ph no._____

Email_____

Medicare no._____

Do you have private health insurance ancillary/extras cover? _____(Fund name)

Do you receive a government pension? Yes / No

Expiry date_____

(Please note this does not include a Health Care Card)

Do you wish to receive other clinic information in the future (eg. newsletters, information about other clinic services, notification of new services etc)? Yes / No

Would you like to receive ***appointment reminders*** via SMS or email, both, or none? _____

Please note we require 24 hours' notice of appointment cancellations to avoid a cancellation fee.

How did you hear about our clinic?

- ☐ Friend/Family Name:_____
- ☐ GP/Other practitioner Name: _____
- ☐ Signage/brochure
- ☐ Internet What did you search via (eg Google)? _____
- ☐ Yellow pages Digital or book? _____
- ☐ Newspaper

Is your consultation covered under any of the following schemes?

Chronic Disease Management (CDM) Plan
GP Name_____ Provider number_____
Referral date_____ Number of consultations_____

GP Mental Health Care Plan
GP Name_____ Provider number_____
Referral date_____ Number of consultations_____

DVA
DVA number_____ GP Name_____
Date of referral_____ GP Provider number_____

Work Safe
Date of injury_____ Claim number_____
Employer Name & Address_____
Insurer's Name & Address_____

TAC
Date of accident_____ Claim number_____

TERMS AND CONDITIONS

1. We expect you to disclose your full medical history to the best of your ability.
2. We expect you to arrive on time for your appointment.
3. We expect you to pay for any consultation and product at the time of the appointment.
4. We expect you to adhere to our cancellation policy. This requires you to give us 24 hours advance notice of any change to or cancellation of your appointment. Less notice will incur a cancellation fee.
5. Our clinic uses web-based practice management software. You consent to information on this program being encrypted and stored by third party IT providers outside of Australia.
6. We endeavour to provide you with quality care at all times. We may ask you to complete a Feedback form to help us to monitor and improve our service.
7. We value recommendations from our clients to their family and friends, and trust you will be happy to refer to us in the future.

PRIVACY POLICY

To ensure your privacy, this Practice adheres strictly to the National Privacy Principles of the Commonwealth of Australia privacy legislation.

Your health information is collected by us only with your consent and as necessary for the proper and effective treatment of your condition. Health information about you will not be released to any other party including other treating health providers without your consent.

You may review your health information with your treating provider at any time and are entitled to access your health records for this purpose. If you have any concerns about the confidentiality of your health information, please feel welcome to discuss these with your treating provider.

Client's signature_____ Date_____