Colorectal Surgeons Sydney Pty Ltd.

Phone: 1300 265 666 **Fax** (02) 9475 0057 **All Mail to:** PO Box 749, Crows Nest, 1585.
Email: staff@colorectalsurgeonssydney.com.au

Patient Information Sheet

Mr/Mrs/Ms/Miss/Other _____ _____ _____
Title (Circle one) **First Name** **Surname**
Address:
_____ _____ **Home Phone** _____

Suburb _____ _____ **Work Phone** _____

State_____ **Postcode** _____ _____ **Mobile** _____

Date of birth _____ _____ _____ **Email**_____
(private & sensitive information regarding your condition will be emailed to the above address)

Medicare No._____ _____ **Reference on card** _____ **EXP**_____

Private Health Fund _____ ____**Membership No.** _____ __**Ref** _____

Heath Care/Pension/DVA Card Number _____**Type(circle)** Aged Pension/DVA/Other

Nex of Kin Name and Contact Number _____ __ _____

Referring Doctor _____ Specialist/GP referral (circle one)

Usual GP (if different from above)_____**Usual GP Phone No** _____

Are there other medical practitioners you would like correspondence to be sent to apart from your referring doctor and usual GP?
If so, please list then:
Name Address Phone

_____

_____

CONSENT TO COLLECT PATIENT INFORMATION

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

- I understand the reasons why my information must be collected.
- I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.
- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
- I understand that if my information is to be used for any purpose other than the above, my consent will be sought.

CONSENT TO CANCELLATION POLICY

- Waiting lists for consultations and surgical procedures are often booked far in advance. Therefore, to avoid under-utilisation of the waitlist, a cancellation fee of $150 will be charged for any cancellation of consultations within 24 hours and cancellation of a hospital procedure will incur a cancellation fee $250 if cancelled within 48 hours of planned procedure. Cancellation fee payment is required before any further booking can be accepted.
- I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.
- I have read the information above information concerning CONSENT AND PRIVACY POLICY and CANCELLATION POLICY and agree to these terms

ZERO TOLERANCE - ABUSIVE BEHAVIOUR

This practice has a zero tolerance for abusive behaviour and reserves the right to refuse treatment to any person behaving in an abusive manner with our secretarial staff.

CONSENT TO PER RECTAL EXAMINATION

Colorectal conditions may require beside examination, sometimes a per rectal digital examination or proctoscopy. This will be discussed with you by your colorectal surgeon, and if you are agreeable verbal consent obtained. If you would like to have one of our staff present as a chaperone in the room when your specialist examines you, then please mention this to the receptionist or specialist. If you feel uncomfortable about having an examination, please mention this to your receptionist or specialist surgeon.

Patient's Name (Please print)

Signature Date