Professor Alkis J Psaltis

MBBS(Hons) PhD FRACS (Orl)

NEW PATIENT REGISTRATION FORM

First Name(s): …….. Surname: ……..D.O.B……

Address: ……..Suburb: …… Post Code……..

Phone No: Home: ……..…..Mobile: ……..……..Email: ……..……

MEDICARE No: …….. Ref: ……. Expiry Date: ……/……..

PRIVATE HEALTH FUND Name: …… ….. Membership Number……..

Hospital Cover: Yes/No/Extras Only

HEALTH CARE/PENSION CARD: Yes/No Type of Card……..

Card No: ……..……..……expiry ……..

GENERAL PRACTIONER

Name: …… Address: ……..……

REFERRING DOCTOR (if not usual GP): ……..

Name: …… Address: ……..……

FEES:

NON-PENSIONER

First Consult	**$260.00**	Medicare Rebate $78.00 ($182.00 gap)
Subsequentconsult	**$170.00**	Medicare Rebate $38.00 ($132.00 gap)

PENSIONERS/HCC

First Consultation	**$170.00**	Medicare Rebate $78.00 ($92.00gap)
Subsequent consult	**$125.00**	Medicare Rebate $125 ($87.00gap)

For your convenience we offer Credit Card (MasterCard/Visa) and EFTPOS facilities. We do not accept Cheques. An up-to-date referral is required to receive a Medicare rebate. Please note that we are a private practice and that we do not bulk bill. Anesthetics and Pathology charges are completely separate to this practice and may involve out of pocket expense.
By Signing I agree to pay for all financial charges arising from the medical consultation and associated services provided by Dr Alkis Psaltis and I acknowledge that ALL debts owed in relation to the provision of services are my responsibility and that all expenses incurred in recovering any debt owed (including hospital fees) are my responsibility.

Patient Name: ..... Date: .....

Signature: .....

HISTORY

Reason for presentation: ……

Duration of symptoms: ……

PAST MEDICAL HISTORY

Asthma Y/N

Heart issues Y/N (Please specify) ……..

Diabetes Y/N

Hypertension Y/N

Bleeding Disorders Y/N

Blood clots……..

Smoker Y/ N / EX

Previous Surgery ……..

ALLERGIES Y/N……..

MEDICATIONS

1……

2……

3……

4……

5……

6……

7……

8……

9……

10……

PATIENT CONSENT TO COLLECT AND DISCLOSE INFORMATION

In accordance with the National Privacy Policy, this practice will ensure your privacy is protected

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below. 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 a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means 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. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.

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

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 other purpose other than set out above, my further consent will be obtained.

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.

Patient Name: ..... Date: .....

Signature: .....

PATIENT CONSENT FOR MEDICAL OBSERVER AND USE OF RECORDED DEIDENTIFIED VIDEOS

Due to Associate Professor Alkis Psaltis' academic and surgical reputation, he frequently has local and international ENT surgeons observe him perform surgery to further their surgical skills. He is also regularly invited to lecture and teach at international conferences and sinus courses. For this reason we require your consent for Associate Professor Psaltis to

1. Allow medical observers observe your surgery. Observers will not be permitted to take photographs/recordings

2. Allow Associate Professor to record parts of your surgery for teaching and education purposes. All recorded information will be de-identified prior to its use and no external facial photos/videos will be taken without your additional consent.

Patient Name: ..... Date: .....

Signature: .....