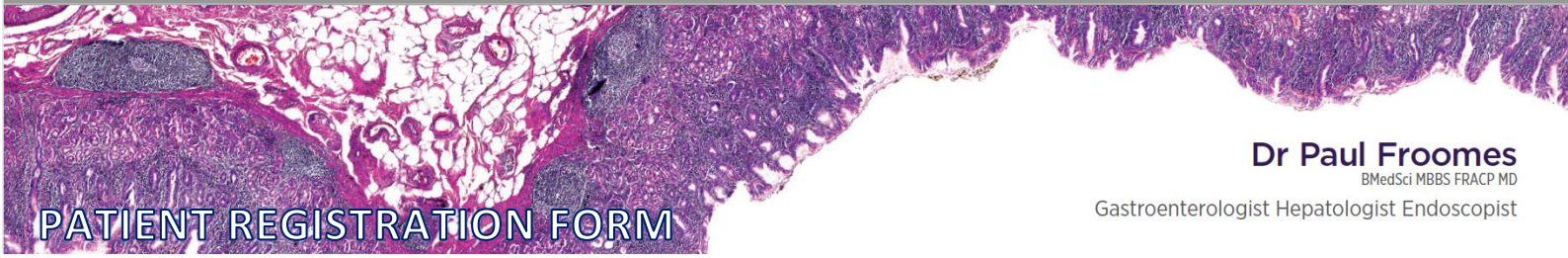

PATIENT REGISTRATION FORM

Dr Paul Froomes
BMedSci MBBS FRACP MD
Gastroenterologist Hepatologist Endoscopist

Personal Details:

☐ Mr ☐ Mrs ☐ Ms ☐ Master ☐ Miss ☐ Mx Other: _____

Surname:	Given Name(s):	
Preferred Name:	Date of Birth:	Gender:
Address:		State:
Postcode:	Do you identify as Aboriginal or Torres Straight Islander?: ☐ Yes ☐ No	
Email:		
Mobile:	Home Phone:	
Emergency Contact Name:		
Contact Number:	Is this your next of kin: ☐ Yes ☐ No	

Referring Doctor Details:

Name of Referring Doctor:	
Contact Number:	Is this your usual GP? ☐ Yes ☐ No
Clinic Name/Address:	
Details of usual GP if not your referring doctor:	

Claim Details:

Medicare Card No:	Ref No:	Expiry Date:
Aged Pension Card No:		Expiry Date:
Disability Pension Card No:		Expiry Date:
Veterans Affairs Card Number:		Card Colour:
Do you have Private Health Insurance? ☐ Yes ☐ No	Fund Name:	
Membership Number:	Do you have Hospital Cover? ☐ Yes ☐ No	
Name as displayed on Fund Card/Policy:		

Do you consent to our clinic using and uploading to your My Health Record? ☐ Yes ☐ No

CONSULT FEE SCHEDULE:

New Referral: $350.00 - Rebate $143.35

Review: $250.00 - Rebate $71.70

Aged and Disability Pension cardholders (Blue Card) will be BULK BILLED. A valid referral must be on file, otherwise full fees will be charged.

PRE-PAYMENT IS REQUIRED FOR VIDEO CONSULTATIONS
The Medicare rebate will be processed after your appointment - a valid referral must be on file.

A $50 fee will be charged for no-shows or cancellations within 24 hours of appointment.

The personal health information that you provide during your consultation and subsequent treatment will be collected for the purpose of providing high quality health care.

The clinic's policy is to protect your privacy and this information is only disclosed to other members of your treating team where necessary. It will, however, be disclosed to other organisations where required by law or, if necessary, for debt recovery purposes. You may gain access to your personal information held by this office by contacting us in writing.

I have read, understood, and agree to the above and I consent to information being released from my medical records as indicated above.

I understand that if I fail to pay an account within the specified period (60 days), my account will then be forwarded to a debt collection agency and additional costs may be incurred.

Signature of Patient/Legal Guardian: _____ **Date:** _____/_____/_____