Eye Surgery Associates

OPHTHALMIC SURGEONS

PATIENT REGISTRATION FORM

PERSONAL DETAILS:	Title: Dr / Mr / Mrs / Miss / Ms _____ *(Please specify)*	Gender: M / F / I / U
Surname:	First Name:	
Known Name:	Date of Birth: ___ / ____ / _____	Occupation:
Address: Suburb:	Post Code:	State:
Email:		
Mobile:	Work:	Home:
Medicare Number: __ __ __ __ / __ __ __ __ __ / __	Patient No: __	Valid To: ____ / _____
Are you of Aboriginal and/or Torres Strait Islander origin? Yes / No / Non Identified		
Pension / Health Care Card Number:		Expiry Date: ____ / ____ / _____
Private Insurance Health Fund:		Membership No:
Veteran's Affairs VX Number:		Expiry Date: ____ / ____ / _____
TAC / WorkCover (Insurer Name):		Date of Accident:
Claim No:	Claim Manager:	Telephone:
Emergency contact:	Relationship:	Telephone:

G.P. Name:		Optometrist Name:	
Clinic Name:		Clinic Name:	
Address:		Address:	
	Telephone:		Telephone:

Do you have any other medical specialists involved with your care? *(e.g. cardiologist, endocrinologist etc.)*

Name:		Name:	
Address:		Address:	
	Telephone:		Telephone:

Shared Personal Information Consent I give permission for the individual(s) nominated below to discuss my personal information including appointments, invoices and medical information with ESA staff. I give permission for ESA to provide this information to those nominated. If left blank, I have declined to provide consent.

Name:	Relationship:	Telephone:
Name:	Relationship:	Telephone:

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EYE SURGERY ASSOCIATES - PATIENT REGISTRATION INFORMATION

Specific Requirements If you are **non-weight bearing** or have **mobility restrictions**, please contact us prior to your appointment to discuss.

Enduring Power of Attorney (Medical Treatment) If you have an enduring power or attorney please provide documentation at your visit and include details under Shared Personal Information Consent.

Communication You agree to receiving electronic correspondence to the email address and mobile phone number provided on this form.

Failure to attend / Cancellation within 24 hours of appointment fee

Standard consultation fees may apply for cancellations and changes within 24 hours of scheduled appointments or for failing to attend your appointment.

Privacy

We endeavour to provide you with optimal medical care. This requires us to collect your personal and health information. It important that we are able to share this information with other clinicians involved in your care. Your information will also be used for verification and identification purposes; administrative and billing purposes; and may be shared with other agencies. These agencies may include Medicare and private health funds required to facilitate claims. Your health information may also be used for research and audit purposes.

Our Privacy Policy contains more information about our privacy practices, including how: we use your information; you may request access to your records; you may correct your personal information; you can lodge a privacy complaint and how we manage such complaints. You can obtain a copy of the latest version of our privacy policy by contacting us or visiting www.eyesurgery.com.au/privacy-policy/

Eye Surgery Associates may use a secure, cloud-based third-party artificial intelligence (AI). This technology is used solely for the purpose of supporting the provision of care by transcribing and summarising information discussed during your appointment. Any collection, use, disclosure, storage and handling of personal information through this cloud-based service is undertaken in accordance with the Privacy Act 1988 (Cth) and the Australian Privacy Principles. Patient consent will be obtained prior to the use.

Fees We are a private clinic. Full payment is required on the day of consultation.

Diagnostic Tests and Minor Procedures: These may be required by your ophthalmologist on the day and offer immediate treatment and management of your condition. Additional fees are charged for these tests and procedures. Some of these fees are not claimable from Medicare. We will endeavour to inform you of these fees on the day. Please ask our staff if you would like more information on these costs at the time they are being performed.

In the unlikely event that your account is referred to a debt collection agency or solicitor, you agree to pay the additional fees incurred in the collection of the debt.

Surgery Estimate: If surgery is required, we will provide a full estimation of costs and details for all surgery bookings.

Forms Completion of external forms such as NDIS, Centrelink and VicRoads may attract an additional fee. Forms usually cannot be completed at the time of your consultation.

I (*print name*) _____ have read and understood the above information regarding the privacy statement, communication, fees, and agree to the above terms.

Signed _____ Date _____

If Guardian, please state relationship to the patient: _____