Patient Privacy Financial Consent Form

We require your consent to collect personal information about you. Please read this carefully, sign where indicated below and bring to your consultation.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with personal details and a full medical history to enable us to 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:

- Administrative purposes in running this medical practice (this may include telephone, email an SMS contact
- Billing purposes, including compliance with HIC requirements (Medicare)
- Disclosure to others involved in your health care, including treating Doctors and specialists outside of this practice. This may occur through referral to other doctors or for medical tests and in reports or results returned following referrals
- Disclosure to doctors performing locum sessions within this practice
- Data may be used in teaching and research

If you have any questions in relation to any of the above matters, please raise these with the Practice Manager.

I have read the information above and understand the reasons why my information must be collected. I am aware that this practice has a Privacy Policy in regard to handling patient information.

I understand that I am not obligated to provide information requested of me, but that my failure to do so might compromise the quality of health care and treatment administered.

I am aware of my right to access information collected about me, except in some circumstances where access might legitimately be withheld. I understand that 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 that set out above my further consent will be obtained.

I consent to the handling of my information by Dr Andrew Apel for the purposes set out, subject to any limitations on access or disclosure that I have given notification of.

I understand that payment of my accounts, in full, is my responsibility and that Medicare and/or my health fund/insurer might not cover the total amount invoice. I am responsible for any further costs that might be incurred resulting from not paying outstanding accounts in full by the due date.

Print Name _____

Signed _____ **Date** _____

Guardian (if applicable) _____

Signed _____ **Date** _____