Patient Information

Dr Anu Kaur

St Andrew's Place, Level 2, 33 North St, Spring Hill, QLD 4000

AURORA WOMEN'S HEALTH

Care with Respect, Dignity, Compassion & Commitment

Patient Details

Title Given name/s _____ _____

Surname _____

Date of Birth / /

Maiden/ Previous Name/s _____

Preferred Name _____

Address _____

Suburb _____ State _____ Post code: _____

Phone:
H) _____ M) _____ W) _____

Email _____

Occupation _____

I consent to receive reminders & messages via SMS/ Email ☐ Yes ☐ No

NOK/ Emergency Contact

Relationship:	Name:	Phone:
_____	_____	_____
_____	_____	_____

Billing and Insurance Information

Medicare No: _____

Ref No. ☐

Expiry date / /

Private Health Fund: _____

Membership No. _____

Ref No. ☐

HHC/ Pension No: _____

Expiry date / /

DVA: _____

Referrals

Referring Dr Name:	Address:	Phone:
_____	_____	_____

Date of referral: / /

Usual GP (if different):	Address:	Phone:
_____	_____	_____

Any other practitioners to be included in correspondence:

Name:	Address:	Phone:
_____	_____	_____
_____	_____	_____

How Did You Hear About Us?

☐GP recommended ☐Specialist ☐Patient/ Friend ☐Health Expo
☐Local directory ☐Internet ☐Facebook ☐Other _____

Aurora Women's Health is committed to providing personalised care for women and their families, in the journey towards parenthood and beyond

Ph: 3839 0552 fax: 3832 1281 admin@aurorawomenshealth.com.au

Dr Anu Kaur St Andrew's Place, Level 2, 33 North St, Spring Hill, QLD 4000

Examination Consent

I understand that many gynaecological and some pregnancy conditions may require examination by the specialist. These examinations may include; breast, abdominal or vaginal examinations (speculum and/or internal). There may also be an indication to perform abdominal or transvaginal ultrasound scans. I acknowledge the above and hereby give consent for such procedures to be performed with the understanding that it is my right to refuse or have an examination cease at any time. I acknowledge that Aurora Women's Health may not always be able to provide a chaperone and, in some instances, I may require an alternate appointment time to be made.

Print Name: _____ Signature: _____ Date: / /

Use and Disclosure of Personal Health Information Agreement

The following information is about the collection, use, disclosure, security, quality, and access of personal information, please read and then sign below where indicated. This consent form will be added to your medical record.

This practice collects personal information from you for the primary purpose of providing quality health care. Aurora Women's Health will ask you to disclose deeply personal private clinically sensitive information. Aurora Women's Health collects information from you to be proactive in your health care and to assess, diagnose and treat your medical condition properly. Not providing this information will restrict our capacity to provide you with the high standard of care that you expect. Information given in confidence is protected by law as confidential information.

Aurora Women's Health is committed to protecting the privacy, the confidentiality and security of any information that you provide to us. To protect your privacy Aurora Women's Health staff must follow the National Privacy Principles under the *Privacy Act 1988*.

There are situations where Aurora Women's Health is required to use or disclose some of your confidential information. These situations may include but are not limited to:

- Administrative requirements of Aurora Women's Health.
- Billing, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to other health care providers, including pathology, medical imaging, doctors, specialists and hospitals outside Aurora Women's Health.
- Disclosure to other Aurora Women's Health medical professionals attached to this practice, these may include Midwives, Nurses, Locums and Registrars.
- Disclosure to the person consenting to the release of information.
- Child abuse and neglect of a child requiring mandatory reporting under the Child Protection Act 1999.
- A court order requiring the release of documents for a proceeding or attendance at the proceeding to give evidence, if your records have been subpoenaed.
- Legal requirements about particular health conditions such as diseases with high public health risk.
- For research and quality assurance activities to improve individual and community health care and practice.
- Debt recovery for services rendered.

Patient's Acknowledgement

I have read the above information and understand why collecting information about me is necessary.
I am aware that Aurora Women's Health has a privacy policy in relation to handling and security of my private and confidential patient information.
I understand that I am not obligated to provide any information requested of me to Aurora Women's Health, however my failure to provide Aurora Women's Health with information requested may compromise the quality health care and treatment provided by Aurora Women's Health.
I have the right to request access to my health record under the *Information Privacy Act 2009*. I am aware that Aurora Women's Health may legitimately withhold parts of my health record in some circumstances.
I authorise the disclosure of my private information by Aurora Women's Health for the purposes set above, subject to any limitations on access or disclosure of which I will notify Aurora Women's Health in writing.
I authorise my insurance benefits be paid directly to aurora Women's Health. I understand that I am financially responsible for any balance.
I authorise Aurora Women's Health or insurance company to release any information required to process my claims.
I understand that should any of the information collected about me be used for any purpose; other that set above, my consent will be obtained.
By signing this declaration form I acknowledge that I have read and understood this form and been given the opportunity to obtain further information from Aurora Women's Health staff.

Print Name: _____ Signature: _____ Date: / /