CIS
Clinical Integration Services

NEW PATIENT DETAILS & CONSENT FORM

This form is to be completed for all new patients of the CIS Group.

☐ Dr ☐ Miss ☐ Ms ☐ Mrs ☐ Mr		
First Name	**Middle Initial**	**Last Name**

Preferred Name (if different)		**Date of Birth:**	
Residential Address			
Postal Address (if different)			
Telephone (Mobile):		**Telephone (Home):**	
Telephone (Work):		**Email:**	
Preferred Contact:	☐ Telephone (mobile) ☐ Telephone (work) ☐ Telephone (home) ☐ Email		
Next of Kin Name (and relationship)		**Contact Number:**	
Method of Payment:	☐ Cash ☐ Card ☐ Cheque		

Medicare No.	_ _ _ _ _ _ _ _ _ _ _ _ _	**Reference No.** *(eg. 1,2,3 etc)*		**Expiry:**	_ _ / _ _

Do you have a Government Issued Pension / Healthcare Card? (Circle)			**YES**	**NO**	
Are you the Primary Card holder?			**YES**	**NO**	
Card Number:		**Card Type:**		**Expiry:**	_ _ / _ _ /_ _ _ _

Do you have a Department of Veterans Affairs Card? (Circle)			**YES**	**NO**	
Card Number:		**Card Type:**		**Expiry:**	_ _ / _ _

Do you have Private Health Insurance? (Circle)			**YES**	**NO**		
Fund Name:		**Member Number:**			**Qualifying Period Met?**	Yes / No
Does Your Health Insurance Cover the following? *(tick if yes)*	☐ Hospital ☐ Cardiac Care ☐ Ambulance					

Referring Dr Name:		**Practice:**	
Family Dr / GP Name: (if different)		**Practice:**	

Please Turn Over

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Privacy Policy

The collection, use and disclosure of your personal information by the CIS Group (CIS, CRS, CVS, CNS) is governed by the Privacy Act 1988 (incorporating the Australian Privacy Principles).We require your consent so we can collect, use and disclose your personal information.

What Information Do We Collect and Why?

As a patient of the CIS Group, we require you to provide us with both personal information (such as contact and billing details) and information on your health and medical history, so that we may properly assess, diagnose, treat and be proactive in addressing your healthcare needs. We securely store and protect the privacy of your personal and health information at all times.

What May We Use This Information For?

We may collect, use and disclose this personal and health information for the following reasons:

- Accurate diagnosis and medical management;
- Disclosure to other doctors or other Allied Health Professionals in our medical practice for purposes of patient care and teaching;
- Disclosure to others involved in your healthcare such as your treating doctor and specialists outside our practice - This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals;
- Administrative Purposes (including Medicare and Health Insurance purposes);
- To comply with any legislative or regulatory requirements, such as notifiable diseases and;
- For reminders and recalls which may be sent to you regarding your health care and management.

What If My Information Changes?

If your personal information changes or you wish to access your personal information held by the CIS Group, please advise one of our Staff Members.

Note: This consent form is a summary of our Privacy Policy. You can request a copy of our full Privacy Policy by speaking to a CIS Group Staff Member or by contacting the CIS Group Contact Centre on 1300 887 997 for assistance.

By taking part in procedures/consultations you agree to the following:

- The CIS Group operates a private billing practice and requires payment in full on the day of the consultation/procedure. By taking part in the consultation/procedure you agree to accept liability for these charges/fees.
- If you are loaned any equipment by the CIS Group as part of your testing or treatment you are responsible for returning these items to the CIS Group on time and free from fault or damage. By taking part in the consultation/procedure you agree to accept liability for replacement or repair costs if equipment loaned to you is not returned, or is returned with damage or faults.
- Please speak with one of our Staff Members if you require further information about our fees/charges or billing policy.
- Results and reports will be issued directly to your Referring Doctor. If you require a copy of your results/reports, please obtain these directly from your Referring Doctor.

Patient Privacy/Personal Information Consent:

I acknowledge that:

- I consent to the handling of my information by the CIS Group for the purpose set out above, subject to any limitations on access or disclosure that I notify to the CIS Group.
- 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 health care and treatment given to me.
- If my personal and health information is to be used for any other purpose other than that set out above, my further consent will be obtained (unless otherwise ordered by a court of law).

Signature:		**Date:**	