NUREVA PRIVACY INFORMATION & CONSENT FORM

COLLECTION OF PERSONAL INFORMATION As a patient of our medical practice, we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs. We aim to protect the privacy of your health information.

We require your consent to collect your personal information, and for its use in the following ways:

- Administrative purposes.
- Billing purposes in compliance with Medicare requirements.
- Disclosure to others involved in your healthcare. This includes your treating doctor and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice for the purpose of patient care and teaching.
- To comply with any legislative or regulatory requirements, such as notifiable diseases.
- For reminders and recalls which may be sent to you regarding your health care and management.

I consent to the handling of my information by this practice for the purposes set out above.

Full Name: _____ D.O. B: _____

Signed: _____ Dated: _____

PAYMENT PROCEDURES & CONSENT You are required to pay your account at the time of consultation. Please advise the receptionist if you are unable to do this **prior** to your appointment. This practice uses a Debt Recovery service for overdue accounts. Any charges incurred for this service will be passed on to the patient. We understand you may need to cancel your scheduled appointment, please notify us as soon as possible, however if an appointment is missed or cancelled without 1 business days' notice a fee may be incurred.

I understand my obligation with regard to payment of my account.

Full Name: _____ D.O.B: _____

Signed: _____ Dated _____

IMAGES & VIDEO Education and teaching is an important part of the practice and the use of images and video is sometimes used for research and teaching purposes of other healthcare professionals. The images and data are kept strictly confidential and your name, DOB, and all other identifying details are removed prior to their use. Please sign and date below if you consent to the use of your images and video.

I consent to the use of my images and video by this practice for the purposes set out above.

Full Name: _____ D.O. B: _____

Signed: _____ Dated: _____

NUREVA WOMEN'S SPECIALIST HEALTH

Wholistic Excellence in Women's Health
www.nureva.com.au

139 Dumaresq St, Campbelltown 2560
All correspondence PO Box 1122, Campbelltown 2560

Phone: 02 4628 5292
Fax: 02 4628 0349

Nureva Women's Specialist Health is committed to providing our patients with the best possible care. In order to do this effectively, it may become necessary to obtain your previous test results, doctor's reports and operation records from other parties whilst you treated at our practice.

As with all your health information that we hold, we aim to protect your privacy by complying with the current legislation guidelines.

REQUEST FOR MEDICAL INFORMATION

Dear Doctor,

The patient below now attends this practice, and has provided their consent below. Could you kindly forward the following information at your earliest convenience.

- ☐ Patient Full Medical Record Summary
- ☐ Recent Specialist Letters
- ☐ Recent Histopathology and Blood Test Results
- ☐ Recent Operation Reports & Discharge Summaries

I give permission for Nureva Women's Specialist Health to collect my medical information for the purposes set out above.

Full Name: _____ D.O. B: _____

Signed: _____ Dated: _____

Please forward the information requested to

Nureva Women's Specialist Health either by email or fax.

Fax: 4628 5292

Email: admin@nureva.com.au