New Patient Registration Form

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master

Surname: First name: Middle name:

Date of birth: Email:

Address:

Suburb: State: Postcode:

Telephone: (Landline) (Mobile)

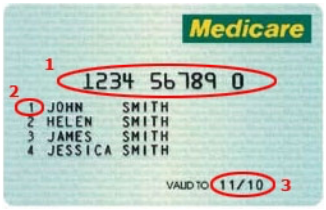
Marital status: ☐ Never married ☐ Married ☐ De-facto ☐ Divorced ☐ Widowed ☐ Separated

*****PLEASE COMPLETE THIS SECTION IN ITS ENTIRETY*****

1. Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

2. Medicare Card Reference (next to your name): ___

3. Expiry: /



Department of Veterans' Affairs (DVA) Gold Card Holder?: ☐ NO ☐ YES

If YES, please provide number: Expiry:

Next of Kin

Name: Relationship:

Address:

Suburb: State: Postcode:

Telephone: (Landline) (Mobile)

Do you authorise us to contact your next-of-kin and liase with this person about your appointments and treatment? ☐ YES ☐ NO

Is this visit related to Worker's Compensation or CTP? ☐ NO ☐ YES

If YES, from which STATE?: Claim No:

Some consultations do not attract a Medicare rebate. I therefore acknowledge that this consultation may incur a fee.

Signature: ***Date:***

New Patient Medical Information

Name: Date of birth:

Do you identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Do you require an interpreter? ☐ No ☐ Yes – language/sign:

Private health insurance that covers HOSPITALS? ☐ NO ☐ YES

Private health insurance that covers EXTRAS? ☐ NO ☐ YES

Do you have a Health Care/Pension/Concession Card? ☐ NO ☐ YES

If YES, please provide Number: Expiry:

Do you have a **regular** GP? ☐ NO ☐ YES (please detail)

Doctor: Medical Centre:

Previous psychiatric hospitalisations? ☐ NO ☐ YES (please detail)

When *Where* *Reason* *Length of stay*

Have you ever seen a mental health clinician? ☐ NO ☐ YES (please detail)

When *Type of clinician(Psychiatrist/Psychologist etc)* *For how long* *Current?*

PREVIOUS and CURRENT Mental Health Diagnosis? ☐ NO ☐ YES (please detail)

What diagnosis Who diagnosed you (GP, specialist etc) When? On treatment?

Alcohol or illicit substance use, CURRENT or PAST? ☐ NO ☐ YES (please detail)

Type *Frequency* *Amount* *Currently using?* *Last used*

Family history of MENTAL illness (eg. depression, anxiety etc)? ☐ NO ☐ YES (please detail)

Relationship *What illness* *Formally diagnosed?*

General Physical Health ☐ Generally fit and well ☐ Current Medical Issues (please detail)

Medical conditions (eg. hypertension, diabetes etc) *On treatment?*

Name: **Date of birth:**

CURRENT medications? ☐ NO ☐ YES (please detail)

Name of medication *Dose* *Frequency*

Previous PSYCHIATRIC medications? ☐ NO ☐ YES (please detail)

Name of medication *Dose* *When* *For how long* *Date ceased*

Medication allergies? ☐ NO ☐ YES (please detail)

Name of medication *Reaction*

Current living arrangement

Who do you live with? ☐ Alone ☐ With others – ***who***:

Do you: ☐ OWN ☐ RENT PRIVATELY ☐ BOARD ☐ HOUSING COMMISSION

Main sources of income:

- ☐ Private income
  - Occupation:
- ☐ Centrelink
  - ☐ NewStart/Unemployment
  - ☐ Disability Support Pension
  - ☐ Single Parent Pension
  - ☐ Aged Pension
  - ☐ Widow's Pension
  - ☐ Others (please state):
- ☐ WorkCover, ComCare or other insurance
- ☐ Nil (dependent)

The information provided above is solely for the purpose of your clinical care. By signing below you agree for this information to be shared with other relevant clinical care providers involved in your care, and give consent for this practice to obtain relevant clinical information about you from other parties.

Signature: **Date:**

Consent to Treatment & Authority to Release Information

I, _____, Date of Birth:_____, of

(address)_____

hereby authorise and consent to any doctor, health professional, hospital or other health institution or rehabilitation provider to discuss with and provide to ***The Shrink Company***, any reports, clinical notes or other relevant information relating to this, or other related conditions.

I authorise and consent to any doctor, health professional, hospital or other health institution, WorkCover, ComCare, Department of Veterans' Affairs, and the above mentioned parties disclosing, releasing, or discussing records containing my personal medical information, between one another.

I understand that the medical information is required to assist with my medical and/or psychological care. I acknowledge that information may be disclosed to other third party without my prior consent under certain circumstances such as when there is the potential of serious physical danger to myself or someone else, risk of child abuse, an enquiry from a legal parent or guardian (if aged under 18), or information legitimately subpoenaed by a court or otherwise authorised for release by law.

I consent to my information being provided to the Gold Coast/North Coast Primary Health Network and to the Department of Health to be used for statistical and evaluation purposes designed to improve mental health services in Australia. I understand that this will include details about me such as date of birth, gender and types of services I use but will not include my name, address or Medicare number. I understand that my information will not be provided to the Department of Health if I do not give my consent. I also understand that my consent is not required for the Department to include data about my use of services in summary reports about the activities funded by Gold Coast Primary Health Network because these do not require personal information to be provided and contain only combined information from many clients that will not identify any individual.

The Shrink Company uses unique identifiers to identify patients. In order to reduce errors, The Shrink Company utilises patient photographs to improve patient identification. I consent to my photograph being taken and kept against my electronic medical records, for the purpose of identification.

I understand that it is my responsibility to keep track of, and disclose the accurate number of Medicare-rebated sessions I have utilised. I understand and accept that I will be responsible for any consultation fees that are not rebated by Medicare for any reason, including if my rebate-able session numbers exceed the annual overall quota (e.g.10 sessions per calendar year for Psychologists).

I understand that if for some reason I need to cancel or postpone an appointment, I must notify The Shrink Company at least 24 hours prior to the appointment. Failure to do so will subject me to a cancellation fee of 100% of the appointment cost, and no further appointment will be offered until this is settled. THIS FEE IS NON-REBATEABLE from Medicare or any other funding bodies. I acknowledge and accept this Cancellation Policy.

All our staff are trained and dedicated to serve you and you will be treated with courtesy and respect at all times. In return, we ask that you and anyone that you bring with you to the Practice treat our administrative and clinical staff with the same courtesy and respect.

We have a ***ZERO TOLERANCE*** approach to any verbal or physical aggression towards any of our staff or other patients or visitors. We respectfully advise you that abuse and/or violence will not be tolerated. Any breach will result in the offender being asked to leave the premises immediately and will not be permitted entry or provided with any service in the future. Extreme cases will result in offenders being reported to the police. This applies to any contact, including telephone, electronic or in person. I accept and agree to abide by this ***ZERO TOLERANCE Policy***.

Sessions cannot commence without your consent. Before giving this consent you may ask your practitioner any questions relating to the techniques or procedures to be followed. There may be a fee associated with any consultation, with any practitioner.

I authorise and consent to a photocopy of this Authority being sufficient evidence of my authority and consent to discuss or provide the medical information requested.

Signature: **Date:**