Kristina Barisic
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Queensland
PAEDIATRIC SPECIALISTS

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Patient Information/Consent Form

PATIENT DETAILS

Surname:_____ Given Name:_____

Street No/Name:_____ Sex:M/F/Other

Suburb :_____Post code:_____

Date of Birth: _____/_____/_____ School / Daycare: _____

Medicare Number: _____ Ref No: _____ Expiry Date: _____

Private Health Insurance YES/NO Private Health Fund Name: _____

Patient Member Number: _____ Patient Ref No: _____ Expiry Date: _____

PARENT/GUARDIAN - ACCOUNT HOLDER DETAILS *(for Billing purposes)*

Surname:_____ Given Name:_____ DOB: ____/___/____

Relationship to Patient: _____ Is your address the same as the patient? YES/NO

Contact Numbers - Mobile : _____ (H)_____ (W)_____

Email: _____ *(Mandatory – not for advertising purposes)*

PARENT/GUARDIAN

Surname:_____ Given Name:_____ DOB: ____/___/____

Relationship to Patient: _____ Is your address the same as the patient? YES/NO

Contact Numbers - Mobile : _____ (H)_____ (W)_____

Email: _____ *(Mandatory – not for advertising purposes)*

Do you consent to be contacted via SMS *(text message)* for appointment reminders or other messages from Queensland Paediatric Specialists? **YES**/**NO**

Are there any current Custody Arrangements or Court Orders in place for this child? YES/NO

(If you answered yes, please discuss this in more detail with your doctor during your first consultation)

Referring Dr Name: _____ Clinic/Suburb: _____

Patients GP Name: _____ Clinic/Suburb: _____

REFERRALS

If you intend to claim through Medicare you will need to make contact with your GP prior to your appointment to determine if you are eligible for a Mental Health Care Plan. Please advise our staff if you wish to claim from Medicare with your MHCP. NDIS patients are required to provide full details of their funding prior to any appointments for clarification from their clinician. If you intend to claim from your private health insurance fund you will need to speak with them prior to you appointment to determine if you are covered for psychology services. The doctors at Queensland Paediatric Specialists offer internal referrals for our doctors or allied health professionals that they deem appropriate for your child. We wish to advise you that you are not required to accept the internal referral and are within your rights to ask for an external referral to another doctor or allied health professional located outside of the Queensland Paediatric Specialists clinic.

RECORDS POLICY

I/We hereby give consent to Queensland Paediatric Specialists and its staff to collect and record information (inc. photographs/videos) in relation to my child as deemed necessary. I/We do hereby release to the Queensland Paediatric Specialists all rights to utilise these patient records in print/and or electronic form privately, or for research, educational purposes and review by other Medical Professionals.

PRIVACY POLICY

I/We understand that the Queensland Paediatric Specialists are bound by the Privacy Act. I/We therefore consent to the disclosure of any information as is necessary to provide for the care of my child and also the use of email as the chosen method of communication at this practice. I understand that this consent may be withdrawn at my request at any time by informing the clinic in writing.

FINANCIAL POLICY

Any procedures and examinations conducted in this practice may incur an additional fee which is the responsibility of the parent/guardian.

I, _____ consent to the handing of my child's information by this practice for the above purposes and any additional charges incurred relating to the services provided.

Signature: _____ Date: _____