**VINEYARD MEDICAL CENTRE**
2–6 Sussex Court, Sunbury, VIC 3429
Ph: (03) 9216 5600 | Fx: (03) 9216 5699
www.vineyardmedicalcentre.com.au

# Patient Registration Form

## 1. Contact Information

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other: _____
First Name: _____ Surname: _____
Date of Birth: __ / __ / _____ Gender Identity: _____
Pronouns: ☐ she/her ☐ he/him ☐ they/them ☐ other: _____
Address: _____
Postal Address (if different): _____
Mobile: _____ Home: _____ Work: _____
Email: _____

## 2. Cultural Background (Optional)

Are you of Aboriginal and/or Torres Strait Islander origin?
☐ No ☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Both
Country of Birth: _____
Language Spoken at Home: _____
Interpreter Required? ☐ No ☐ Yes – Interpreter / Auslan

## 3. Emergency Contacts

Primary Contact: _____ Relationship: _____
Phone: _____ Mobile: _____
Next of Kin (if different): _____ Relationship: _____
Phone: _____ Mobile: _____

## 4. Healthcare Details

Medicare No.: _____ Ref: __ Exp: __ / __
DVA Card No.: _____ ☐ Gold ☐ White
Pension/Health Care Card No.: _____ Exp: __ / __

## 5. Health Information

Allergies? ☐ No ☐ Yes – Please list: _____

_____

Current Medications? ☐ No ☐ Yes – Please list: _____

_____

Height: ___ cm Weight: ___ kg
Do you: ☐ Smoke ☐ Don't smoke ☐ Drink alcohol ☐ Don't drink alcohol

## 6. Billing and Appointment Policy

1. Full payment is required on the day of service.
2. Unpaid accounts may incur a $15 administration fee. Overdue accounts sent to collections will include additional recovery costs.
3. At times, your doctor may need to add additional Medicare item numbers and associated fees depending on the type of consultation and discussions held. These fees will be explained to you if applicable.
4. You understand there may be additional charges incurred beyond the standard consultation fee if any additional tests and/or procedures are required.
5. You understand a non-attendance fee as set by your doctor will be applicable for any missed appointments.
6. You understand a late cancellation fee as set by your doctor will be applicable for any appointments cancelled with less than 4 (four) hours of notice.
7. If you have any questions or concerns about any of the information on this form, you will request to speak to the Practice Manager or notify the Practice Manager in writing.

## 7. Your Privacy and Medical Records

1. In accordance with section 6(1) of the *Privacy Act 1988* (Cth) (**Privacy Act**), all information collected in this medical practice is treated as 'sensitive information'. To protect your privacy, Vineyard Medical Group Pty Ltd ACN 603 337 677 as trustee for the Vineyard Medical Centre Unit Trust ("**Practice**") operates in accordance with the Privacy Act and its Privacy Policy. A copy of our Privacy Policy is available free of charge from reception or on our website at **www.vineyardmedicalcentre.com.au** .
2. Your doctor uses the information you provide to manage your health care, which may include using the information for the following purposes (including instructing the Practice to use the information for the following purposes on your doctor's behalf):
    a. Collecting, recording and storing your personal and health information that will form part of an individual computerised medical record.
    b. Issuing reminders for specific health checks that you may require, if any, as part of your consultation with your doctor and/or nurse.
    c. Providing you with health information updates, general medical updates and provide your personal and health information to the relevant state and/or national recall reminder registers.
    d. Using your personal and health information to undertake, however not limited to; administrative tasks involved in the running of the Practice, and for your doctor, billing tasks which includes

compliance with Medicare, Health Insurance Commission and other relevant Government agency requirements.

3. You can assist in maintaining the accuracy of your information by advising your doctor or reception of changes in your contact details.

4. Selected information may be disclosed to various other health care providers involved in supporting your health care management (e.g. pathology and imaging providers, hospitals or other specialists). You hereby acknowledge and consent to the disclosure and/or use of your personal health information by the Practice, your doctor and persons directly or indirectly involved in your personal health care or medical treatment for that purpose, including:

    a. Sending specimens obtained from you to the necessary pathology provider for analysis. As a result, you understand that you may incur an out-of-pocket expense, by which a separate invoice will be issued by the relevant pathology provider. You understand that you will be liable for all expenses incurred.

    b. Disclosing your personal and health information to the relevant medical and allied health service providers involved in your care.

    c. Disclosing de-identified personal and health information for research and quality assurance purposes undertaken by your doctor to improve the quality of both individual and community health care needs and medical practice management. The Practice will inform you when such activities are being conducted and give you the opportunity to 'opt-out' of any involvement at any time.

    d. Using your personal and health information by your doctor and other authorised individuals involved in your medical care and treatment, both directly and indirectly.

    e. Disclosing for legal related purposes as requested and required by a court or other regulatory body.

    f. For medical training/teaching purposes where de-identified information is disclosed to medical students and staff.

    g. For disease notification as required by the law.

5. You are not obliged to provide information requested of you, however your failure to do so may compromise the quality of care provided to you by your doctor.

6. You understand your right to access both your personal and health information held by the Practice, except in circumstances where access is legitimately withheld. If your personal and health information is to be used for any other purpose, other than what is set above, your further consent will be obtained.

7. You understand it is your responsibility to inform the Practice at the earliest of any changes to your personal and health information. If any information held about you is inaccurate, you may request to have this altered accordingly.

8. Your doctor may use Lyrebird, an artificial intelligence scribe program, to record and summarise your appointment, assist in telehealth consults and store the transcript in your medical record. These notes will be reviewed by your doctor to ensure they accurately reflect your appointment before they are relied upon to provide medical advice. Lyrebird's privacy policy is available from reception or on Lyrebird Health's website here. Please talk to your doctor if you have any questions.

## 8. Patient Consent

By signing below, I consent to:
- My personal and health information being collected and used for treatment and care by my doctor.
- Information sharing with other providers for my medical care.
- Use of de-identified data for quality assurance and training.
- Receiving recall/reminder communications via SMS, email, or phone.
- Clinical photographs being taken if required for diagnosis or treatment.
- Voicemail/SMS messages being left if necessary.
- Compliance with the practice's privacy policy: https://www.vineyardmedicalcentre.com.au/privacy-policy
- The use of Lyrebird, an artificial intelligence scribe program, to transcribe your doctor's consultation notes and to assist in telehealth consults, in accordance with privacy and confidentiality obligations.

You may withdraw or update consent at any time by notifying reception.

Preferences:
Receive SMS/email reminders & recalls ☐ Yes ☐ No
Clinical photos for diagnosis/treatment ☐ Yes ☐ No
Leave voice messages (reminders/results) ☐ Yes ☐ No
Receive health awareness info ☐ Yes ☐ No

Patient Name: _____ Signature: _____ Date: __ / __ / ___
If not the patient:
Name: _____ Relationship: ☐ Parent ☐ Guardian ☐ Medical POA* ☐ Other: _____
(*Copy of Medical POA required)

**Photo ID required for all new patients**

**Privacy Collection Statement**

Vineyard Medical Group Pty Ltd ACN 603 337 677 as trustee for the Vineyard Medical Centre Unit Trust collects your personal information for purposes related to (or in the case of sensitive information, directly related to) our functions or activities, including facilitating the delivery of health services to you from your

health practitioner, informing you of services which may be relevant to you and to communicate with you on behalf of your health practitioner. We may not be able to facilitate the delivery of health services from your health practitioner to you if you do not provide this information. Your personal information may be disclosed to our related bodies corporate, health practitioner, and third-party services providers. Your personal information is kept private and secure, as required by federal and state privacy laws.

Please refer to our Privacy Policy for full details of how we handle your personal information, including how you may access and seek correction of your personal information, complain about a privacy breach, and how we will deal with that complaint.

*Thank you for your cooperation & please return your completed form to reception.*