SA-SLP-F-027

PATIENT REGISTRATION & CONSENT

Contact Information	
Name:	
Date of Birth:	Occupation:
Home Phone:	Mobile:
Email Address:	
Residential Address:	
Postal Address: *(if different from above)*	
Referring Doctor:	
Regular GP:	

Next of Kin	
Name:	
Relationship:	Phone Number:

Billing Information			
Medicare Number:		Ref:	Expiry:
DVA Number:	Gold Card Y / N	Ref:	Expiry:
Private Health Fund:	Number:		Hospital Cover Y / N
Pension/Concession Card Number:			Expiry:

I understand that Sleep Australia and associated medical centre's comply with the Privacy Act of 1998 and as part of the privacy policy are committed to protecting the privacy of individuals and their personal information.

My signature below indicates that I have read the above and agree for Sleep Australia to collect, use, store and dispose of my personal information and to release my personal information to other health professionals to allow quality medical care. I agree to the release of relevant personal information to my prospective employer, authorised representative and their insurer (in the case of work related consultation or service). I understand that I may withdraw my consent for Sleep Australia to use and dispose my personal information (except where legal obligations must be met).

I understand the procedure for my appointment and that payment is required on the day of my appointment (unless Sleep Australia has previously received approval from a third party for payment of my account). I consent for the Medicare component of my appointment (for Items 12250 and 11512 or 11503 as appropriate) to be billed directly to Medicare on my behalf.

I understand that in the event that any loan equipment is damaged due to misuse, I may be liable for a fee for the repair.

Signature _____ **Date** _____

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