

# Patient Information Form- Cardiology

Title: \_\_\_\_\_ Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

May we release medical records to your GP and/or other Specialist Drs? (list Dr details below) Yes  No

**Emergency Contact:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**GP/ Specialist Details:**

Dr Name/ Speciality: \_\_\_\_\_

Clinic Name/ Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Medicare & Private Health Insurance Details**

Yes  No

Medicare Number: \_\_\_\_\_ Ref No. (next to your name): \_\_\_\_ Exp: \_\_\_\_/\_\_\_\_

**Pls note that if you DO NOT HAVE MEDICARE you will be required to settle your account for all consultations and procedures directly with our clinic at the conclusion of your appointment and/or when booking in for a procedure.**

DVA (Dept of Veteran Affairs) Card Number: \_\_\_\_\_ DVA Card Colour: \_\_\_\_\_

Pension No.: \_\_\_\_\_ Exp: \_\_\_\_/\_\_\_\_/\_\_\_\_ Type (circle): Age /Disability

Private Health Insurance (please tick) Yes  No

Health Fund Name: \_\_\_\_\_ Membership Number: \_\_\_\_\_

Position on card: \_\_\_\_\_

**Pls turn over to read our Health Information Collection and Consent statement and for further information regarding Cardiac Testing (signature required)**

## HEALTH INFO COLLECTION USE AND CONSENT FORM

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 and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information. We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through 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, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management. You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.
- I have read the information above and understand the reasons why my information must be collected.
- I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.
- I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.
- I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.
- I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.  
I consent to the Dr using AI Transcription during our consult for the purpose of accuracy and letter creation.

## CARDIAC TESTING INFORMATION

As you are consulting with a Cardiologist today please be aware that further testing **may be** required as part of the diagnosis process.

**It is VERY IMPORTANT that you inform your Cardiologist and our admin team of any cardiac imaging tests you may have had performed in any public or private hospital/clinic prior to your appointment. Failure to inform us may result in you not receiving a Medicare rebate for the test and you may have to pay the complete cost of the test out of pocket.**

Proposed Procedure Details			
Item Number	Fee	Medicare Rate	Description
55126, 55127, 55133, 55134, 55128, 55129	\$320	\$219.90	Echocardiogram
55141, 55143	\$520	\$392.00	Stress Echocardiogram
11716	\$220	162.25	24 Hour Holter Monitoring (Continuous ECG recording)

### Declaration by Patient or Guardian

- I acknowledge that it is my responsibility to inform my Cardiologist and staff members alike, if I have had any of these tests performed after the 1<sup>st</sup> August 2020 or in the last 12- 24 months, whichever is later.
- I acknowledge that I have been informed of the above fee guide, and agree that the full fee will be my liability in the event that I am not eligible for the Medicare rebate for my test(s).
- I acknowledge that it is my responsibility to confirm my eligibility to have this/these test(s) billed to Medicare
- Fees stated above are subject to change at Medicare's discretion.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_