Hollywood Consulting Centre
3rd Floor - Suite 303
91 Monash Avenue
Nedlands WA 6009

Telephone: (08) 9420 4900
Facsimilie: (08) 9386 9277

(Please circle) Mr Mrs Miss Ms Dr Prof Other:_____ Surname:_____

Given Names:_____ Known As:_____ DOB:_____

Home Address:_____

Suburb:_____ Postcode:_____

Mobile:_____ Home Phone:_____ Work Phone:_____

Email:_____ Occupation:_____

Medicare:_____ Ref Number:_____ Expiry Date:_____

Private Fund:_____ Number:_____

Pension / Concession Card Number:_____ Expiry Date:_____

Referring Doctor:_____ How did you hear about us?:_____

General Practitioner:_____ Phone Number:_____

Next of Kin:_____ Relationship:_____ Phone Number:_____
(Full name)

Declaration *– to be signed by* ***ALL*** *patients.*
I, the above patient, consent to the collection and use of the above information, and all further information requested by and given to ***Dr Julian Rodrigues*** *during this and all subsequent consultations, to help provide an accurate medical diagnosis and to facilitate appropriate treatment, including correspondence to my referring/general practitioner.* ***I am also aware that the accounts are the responsibility of the patient and that the examination will not be fully covered by Medicare and I will be required to pay a gap****.*

Signature:_____ Date:_____

Insurance Claiming

If Worker's Compensation / Motor Vehicle or Criminal Injury, please complete the following details.

Employer:_____ Date of Injury:_____

Insurance Company:_____ Claim Number:_____

I, _____ will be personally responsible for payment of all accounts incurred by me in the event that liability is denied, or placed in dispute.

Signature:_____ Date:_____

PATIENT CONSENT
TO COLLECT AND DISCLOSE INFORMATION

This is the privacy policy for Dr Julian Rodrigues. The Privacy Act 1998 requires medical practitioners to obtain consent from their patients to collect, use and disclose that patient's personal information. This policy outlines how we will collect, store and use your medical information to provide you with the best medical care.

1. COLLECTION

This means we will collect information that is necessary to properly advise and treat you. Such necessary information may include:

- Full medical history
- Family medical history
- Ethnicity
- Contact details
- Medicare / private health fund details
- Genetic information
- Billing / account details

The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources, for example:

- Other medical practitioners, such as former GPs and specialists
- Other health care providers, such as physiotherapist, psychologists, pharmacists
- Hospital and Day Surgery units.

Both our practice staff and the medical practitioners may participate in the collection of this information. In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent.

2. USE & DISCLOSURE

With your consent, the practice staff will use and disclose your information for the purpose such as:

- Account keeping and bill purposes.
- Referral to another medical practitioner or health care provider.
- Sending of specimens such as blood samples for analysis.
- Referral to a hospital for treatment and/or advice.
- Advice on treatment options.
- The management of our practice.
- Quality assurance, practice accreditation and complaint handling.
- To meet our obligations of notification to our medical defence organisations or insurers.
- To prevent or lesson a serious threat to an individual's life, health or safety.
- Where legally required to do so, such as producing records to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases.
- To make available your records to the on call neurology consultant for your medical treatment when the need arises.
- To supply results / reports / recommendations to you referring doctor pertaining to your medical management.

3. ACCESS

You are entitled to access your own health records at any time convenient to both yourself and the practice.
Access can be denied where:

- To provide access would create a serious threat to life or health
- There is a legal impediment to access
- The access would unreasonably impact on the privacy of another
- Your request is frivolous
- The information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings.
- In the interest of national security.

We ask that, where possible, your request be in writing. We may impose a charge for photocopying or for staff time involved in processing your request. Where you dispute the accuracy of the information we have recorded you are entitled to correct that information. It is our practice policy that we will take all steps to record all your corrections and place them with your file, but we will not erase the original record.

4. DATA SECURITY

Information is stored securely in our office, both as files and on the computer. It is also backed up electronically to a secure remote cloud server.
The records will be stored for the time advised or required by law.

5. ANONYMITY

On request, patients have a right to request that they be treated anonymously where this is practical and lawful.

6. SENSITIVE INFORMATION

Sensitive information will only be collected with the patient's consent, or where it is required by law or in other special specified circumstances.

7. CONSENT

- I provide consent to Dr Rodrigues to collect, use and disclose my personal information as outline above.
- I provide consent for results to be sent to my referring doctor by facsimile.
- I provide consent for messages to be left with immediate family members / defacto partners (e.g. appointment confirmation)
- I understand that I am entitled to access my own health records except where access would be denied as outlined above.
- I understand that I may withdraw my consent as to the use and disclosure of my personal information (except when legal obligations must be met)

PRINT PATIENT NAME:_____PATIENT SIGNATURE:_____

WITNESS SIGNATURE:_____DATE:_____

Witnessed by Dr Rodrigues' representative_____

Dr Julian P. Rodrigues
MBBS FRACP
Neurologist
214347RY

Hollywood Consulting Centre
3rd Floor - Suite 303
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Nedlands WA 6009

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Fax: (08) 9386 9277

Appointment Cancellation Policy Agreement:

Dr Rodrigues is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please remember it is **your responsibility** to ensure that you **remember your appointment date and time.**

To assist you, as a courtesy, we have an automated SMS service to send reminders and we will endeavour to contact you on your home phone number if you do not have a mobile to confirm your appointment date and time a few days before it is scheduled. This may include contacting your nominated Emergency Contact person if you are unavailable. Please ensure that you have a message bank or similar facilities enabled on your mobile phone or home phone.

New Case Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care. Any patients who **do not attend their scheduled Initial appointment and fail to give a minimum of 7 days notice** (either by telephone, leaving a message on our answering machine, or emailing admin@drjulianrodrigues.com.au **will be charged a cancellation fee, which is currently $100.**

Any patients who **do not attend their scheduled follow up appointment and fail to give a minimum of 48 hours notice** (either by telephone, leaving a message on our answering machine, or emailing admin@drjulianrodrigues.com.au **will be charged a cancellation fee, which is currently $50. Please call us at 9420 4900 by 9:00 a.m. two days prior to your scheduled appointment** to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 9:00 a.m. on *Thursday*.** If prior notification is not given, you will be charged for the missed appointment.

Any patient arriving fifteen (15) minutes late to his/her appointment will be considered a 'no show', will need to be rescheduled and fees apply. Below are circumstances associated with the **Late Policy**:

If you are **running late** for your appointment, please check that you can still be seen. If a patient calls via phone to notify the clinic they will be up to ten (10) minutes late for their appointment, or if the patient presents to the office ten (10) minutes late, the receptionist will need to check with Dr Rodrigues to see if you can be worked into his schedule, if not, then this will be deemed a late cancellation per our cancellation policy.

It is the patient's responsibility to ensure that a valid referral (including an updated GP referral every 12 months) is obtained before the scheduled appointment time. Failure to obtain this is not an acceptable reason for cancelling an appointment even though you may choose not to proceed and **a cancellation fee will be charged.** We **will** see you without a referral but you **will not be entitled to a Medicare rebate** if you choose this option. Our staff will remind you if your referral is due to expire when making your appointment.

Another appointment will **only be given after the cancellation fee has been paid in full**

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact Carol, who may be able to waive the No Show fee.

Please sign below to consent to these terms.

Declaration *– to be signed by* ***ALL*** *patients.*

*Signature:*_____ *Date:*_____