

PATIENT INFORMATION FORM



TITLE MR MRS MISS MS MASTER DR

D.O.B.

SURNAME PREV. SURNAME (If applicable)

FIRST NAME MIDDLE NAME(S)

RESIDENTIAL ADDRESS

SUBURB POSTCODE

POSTAL ADDRESS (If different to residential address)

TEL No. (home) (work) (mobile)

MEDICARE No. Ref No. (next to your name) EXPIRY

DEPT. of VETERANS AFFAIRS No. Gold or White EXPIRY

PENSION / HEALTH CARE CARD No. EXPIRY

OVERSEAS VISITOR? Yes No EMAIL

GUARDIAN DETAILS (must be completed if patient under 18)

NAME

POSTAL ADDRESS

MEDICARE No. Ref No. (next to your name) EXPIRY

RELATIONSHIP TO PATIENT D.O.B.

Account Information

SKG Radiology is a private practice with a private billing policy. SKG caps the maximum amount that any patient is expected to contribute towards the cost of services. Our fees reflect the high cost of technology purchases & maintenance, provision of after-hours 24-hour 365-days per year services and the Radiologist's time to carefully view, interpret and report the images. The fees that are charged will vary depending upon the examination or procedure. As a private billing practice, we require payment on the day. For out-patients, you will be charged the full amount, then by utilising Medicare online claiming, receive the Medicare rebate directly in your account within 48 hours. We encourage you to ask about the costs of your procedure at the time of booking your appointment. By signing this form, you are acknowledging our account terms.

Privacy Information

SKG Radiology is committed to protecting the privacy of our patients and complies with the Privacy Act (1988). We collect, use, store and disclose your personal information:

- To complete the examination or procedure you have requested us to perform;
- To make information available to your referrer and / or other health care providers involved in your medical management via our secure information systems;
- To manage our practice, including billing and collection of accounts; and
- As permitted or required by law.

Your specific consent will be obtained prior to any trans-border image transfer. If we cannot collect, use and disclose your personal information, we may not be able to provide our services to you. Privacy requests should be discussed with our staff. Certain requests may reduce the efficiency of the health care services provided. By signing below, the patient / legal guardian confirms that they:

- Have read and understood the information provided above;
- Have requested further information if required;
- Have discussed specific privacy requests with staff; and
- Consent to SKG Radiology collecting, using, disclosing and otherwise handling their personal information in the manner described above, unless otherwise discussed with and agreed to by our staff.

Please refer to www.skg.com.au for further details or ask us to provide you with a copy of our **Account Information for Patients** or **Privacy Information for Patients**

Signature of **Patient** or Legal Guardian

Signature of SKG Radiology Witness

Date