NEXUS NEUROLOGY

Suite 42, Wexford Medical Centre
3 Barry Marshall Parade, Murdoch WA 6150
T 08 9332 2861
F 08 9312 1576
contact@nexusneurology.com.au
nexusneurology.com.au

Patient Registration

Mr / Mrs/ Miss/ Ms/ Dr/ Other

Surname: _____ First name(s): _____

Address:_____ Suburb: _____ P/code: _____

Date of Birth: _____ Email:_____

Phone (Home):_____ (Wk):_____ (Mob):_____

Occupation: _____

Medicare no_____ Ref:_____ Exp: _____ / _____

Veteran's Affairs #: _____ White / Gold / Orange

Next of Kin: _____ Relationship: _____ Phone:_____

Referring Doctor: _____

General Practitioner if different from above:_____

Person responsible for account if different to above **(ie. if *patient is a minor*)**

Name: _____ DOB: _____

(This is a private billing practice and payment on the day of consultation is required)

Consent: I understand that Nexus Neurology and the Doctors within the Group comply with the Privacy Act (1988). The purpose for collecting my personal information is to provide quality medical and health related services and associated account keeping. I understand that I have the right to request access to my information (except where access would be denied) and that Nexus Neurology and Doctors make every effort to manage my information in accordance with the National Privacy Policy. I understand that I may withdraw my consent for Nexus Neurology and Doctors to use my personal information (except when legal obligations must be met).

PLEASE NOTE
Many neurological conditions must be reported to the Department of Transport if you hold a Driver's Licence. Please visit the website https://www.transport.wa.gov.au or call 1300852722 to check if this applies to you.

I understand it is my responsibility to inform the Department of Transport if I have a reportable condition.

How did you hear about us: GP ☐ other specialist ☐ another patient/friend ☐
migrainedoctor.com.au ☐ sweatdoctors.com.au ☐ internet search ☐

THE USE OF ANY RECORDING DEVICES IS NOT PERMITTED DURING YOUR CONSULTATION

Our Nexus Neurology staff come to work to care for others, and it is important for all members of the public and our staff to be treated with courtesy and respect. The Nexus Neurology team has a policy that rudeness, swearing, abusive or threatening behaviour from a patient or anyone accompanying a patient to an appointment towards any member of staff or other patients at the practice is unacceptable and will not be tolerated. If a patient or anyone a patient brings with them to an appointment behaves in an unacceptable manner either in person or on the telephone, the Nexus Neurology team reserves the right to discharge the patient from our ongoing care. The patient will be formally notified of this discharge in writing with advice on how to continue their appropriate medical care elsewhere.

Signature: _____ Date: _____(Please turn over)

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CONSENT TO RELEASE MEDICAL INFORMATION FORM

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. 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. This means we will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.

2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.

3. Disclosure to others involved in your health care, 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 the referrals.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand 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 this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

Name……..

Signed…….. Date:……