PLEASE COMPLETE BOTH SIDES OF THIS FORM

AUDIOLOGY PATIENT INFORMATION FORM

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☐ Miss ☐ Ms ☐ Mrs ☐ Master ☐ Mr ☐ Dr ☐ Other

(Please also tick the preferred contact method below)

First Name: ______________________ ☐ Home Ph: ______________________

Preferred Name: ______________________ ☐ Mobile: ______________________

Surname: ______________________ ☐ Email: ______________________

Date of Birth: ______________________ Medicare No: ______________ / ____ Exp: ______

Home Address: ______________________ Pension No: ______________________ Exp: ______

Suburb: ______________________ HSP No: ______________________ Exp: ______

State: ____________ Postcode: ________ DVA No: ______________________ Exp: ______

In case of emergency, please contact:

Name: ______________ Phone: ______________ Relationship: ______________

Referral Details:

Referred by: ☐ GP ☐ ENT ☐ No Referral ☐ Other: ______________________

Referrer's Name & Suburb: ______________________________________

Have you made a return appointment with the person who has referred you?

☐ No ☐ Yes - When?: ______________

(Please provide your usual GP's details below if they are not the person referring you on this occasion)

GP Name & Suburb: ______________________________________

Parent / Guardian / Carer Details *(if applicable)*

Surname: ______________________ First Name: ______________________

Mobile: ______________ Home Phone: ______________ Email: ______________________

Relationship to client: ______________________

Are you the preferred contact who receives all correspondence on behalf of the client? ☐ Yes ☐ No

(If No, all correspondence will be sent directly to the client)

Are the address details the same as the client? ☐ Yes ☐ No *(If NO, complete details below)*

Address:

Suburb: State Postcode

Please note - if your child is aged over 14 years, they they must complete this consent form themselves and authorizing provision of information to parent / guardian.

I, ______________________ *(Name)* on ____________ *(Date)* consent to my parents/ guardian ______________________ *(Name)*, receiving information on my behalf from MorningtonPeninsula Audiology (MPA) including personal medical information relating to my treatment.

Consent for Collection and Sharing of *your* Personal and Health Information

Mornington Peninsula Audiology (MPA) has a fundamental role in ensuring the confidentiality of your 'personal and health information' by adhering to the Privacy Act 1988. We define 'confidentiality' as our obligation not to use this information for any purpose other than for which it was given to us. Our primary purpose for collecting and using your information is to provide you with the best possible health care. Consequently we must obtain your informed consent to collect and share your 'personal and health information' - from yourself directly or from other professionals involved in your health care.

Please read the following and sign where indicated if you consent to the collection and sharing of your 'personal and health information' in the following situations:

1. Discussions directly with you and from data entered on the MPA Audiology Patient Information Form
2. Correspondence with other healthcare providers and administrators including but not limited to Ear, Nose and Throat Specialists (ENTs), Otologists, GPs, Audiologists, Speech Pathologists, Psychologists, Rehabilitative Device Suppliers, and Hospitals.
3. Billing purposes including but not limited to the collection of fees and compliance with Medicare, Hearing Services Program (HSP), Department of Veterans Affairs (DVA), Health Insurance Companies, National Disability Insurance Scheme (NDIS) , Workers Compensation, and Rehabilitative device manufacturers.
4. Release of information to education and other support providers for my child (if applicable).
5. The promotion of new products or services offered by MPA

I, ______________________ have read the information listed in points 1 to 5 above. Should I not consent to a specific circumstance, I have circled that number corresponding to that situation. I understand the reasons why my information must be collected, stored and in some cases disclosed. I am also aware that MPA adheres to the 13 Australian Privacy Principles of the Privacy Act 1988. I understand that this consent will cover all interactions with MPA unless explicitly informed in writing.

Signature ______________________ **Date** ______________

On behalf of my child *(If applicable)* ______________________ DOB ______________

You are entitled to obtain access to the personal information we hold about you and you are not obliged to provide any information requested.