SYDNEY spine&pain

Interventional & Multi-Disciplinary Pain Management

Patient Registration & Authority Form

Patient Details

Surname: ______________________________________ First Name: ______________________________________

Address: ____

Birthdate: _________________________ Gender: Male Female Salutation: Mr Mrs Miss Other _____

Do you want confirmation appointment text messages? Yes No Email: __________________________________

Home Ph: ____________________ Mobile: ___________________ Next of Kin Ph: ________________________

Pensioner: Yes No Pension Card Number: ___________________________

Medicare and Health Fund Details

Private Health Fund: __________________________________ Member Number: __________________________

Level of Cover: Basic Bronze Silver Gold

Medicare Number: ________________________ Reference: ______________ Expiry Date: _________________

DVA: Yes No DVA Card: Gold White DVA Number: ________________ Expiry Date: _________________

Doctor's Details

Referring Dr: ________________________ Ph: _____________________ Clinic Name: ______________________

Address: ____

Your GP (if different from above): ____ Ph: _____________________

Address: ____

Workers Compensation and CTP Details

Workers Compensation: Yes No CTP: Yes No If ***Yes*** *= Complete below* ***No*** *= Go to end.*

Date of Injury: __________________________ Claim No: ____

Insurer: _______________________________ Address: ____

Case Manager: _________________________ Email: ________________________ Ph: ____________________

Solicitor's Name and Address: ____ Ph: ____________________

If Workers Comp, Employer's Name: ____ Ph: ____________________

Address: ____

1. It is acknowledged that the provider may have a relevant interest in third parties that you may be referred to for future treatment. Any further treatment undertaken by third parties is at your own risk and the provider shall in no circumstances have any liability.
2. Under new privacy laws you agree and permit us to release your medical history to your referring doctor, GP, rehabilitation providers, health practitioners and in a workers compensation case or CTP claim; insurance company, case managers and lawyers.
3. In the event of appointment cancellations with less than 48 hours' notice, you will be charged a cancellation fee which is the FULL cost of the consultation. Workers compensation Insurance companies may not pay this fee therefore you, the patient, will be liable to pay this fee.
4. **In the event that the insurance company denies your claim or fails to pay fees incurred at this or affiliated facilities, you acknowledge and accept liability for ALL financial costs incurred for your consultations, treatments and procedures**.
5. ☐ Please tick if you do not give authority for your information and history to be used for research purposes. If your information is studied your name will be de-identified (which means your name will be withheld and not released).

I have read, understood and agreed to the details clearly outlined.

Signature of Patient: ____________________________________ Date: _________________________