Dr Michael Farrell
Head & Neck – Ear, Nose & Throat

M.B., B.S., M.S., F.R.A.C.S.

Head and Neck Surgeon | Ear, Nose & Throat Surgery | Transoral Robotic Surgery

Patient Registration and Consent Form

Please read and complete the following two (2) pages. We need this information to provide you with the best quality care. Accurate details help us identify you and your medical records. Please notify us promptly of any changes to your details.

Title	Δ Mr Δ Mrs Δ Ms Δ Miss Other
Surname	
First Name(s)	
Date of Birth	
Street Address	
Suburb and Postcode	
Home Phone	
Mobile Phone	
Email Address	
Medicare Number	Ref No: Expiry Date:
DVA Gold/White	Expiry Date:
Pension Card	Expiry Date:
Private Health Fund	Name: Ref No:
	Number:
Next of Kin (NOK)	Relationship to you:
Next of Kin	Ph:
Local Doctor (if different to referring doctor)	
Other Doctors, Specialists you currently consult	
Medications	
Allergies	

For Parents/Children

Parent Name if different from NOK:	
Parent Medicare Number: Ref No:	Expiry Date:
Parent Date of Birth:	
Parent Address if different from above:	

Please turn over to consent form

Health Information Collection and Use Consent

As a patient of our medical practice 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. We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information. We require your consent to collect personal information about you and to use the information you provide in the following ways.
This practice complies with the Australian privacy legislation to protect your personal information recorded in electronic and paper records.
Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.
- Your health information will not ordinarily be sent overseas unless you are informed and provide consent and the overseas country receiving the information has privacy laws that are very similar to the Australian Privacy Principles.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

- I have read the information above and understand the reasons why my information must be collected.
- I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.
- I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. 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 understand that I am automatically enrolled into a recall and reminder system and Staff at Dr Michael L Farrell's office may need to contact me via telephone, SMS, email, or post offering health services appropriate to my care, when test results need to be discussed and for appointment confirmations. If I cannot be contacted within a timely period, My Next of Kin may be contacted. I understand that I can be removed from this list at any time with my written consent.
- I understand that while Dr Farrell's office has systems in place to follow-up results of tests and referrals, it is expected that patients also play a role in ensuring that follow-up occurs. Outcomes in health care are a shared responsibility between the patient and their health service provider.
- I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.
- I authorise Dr Farrell's office to electronically process my consultation fee via Medicare online. OR I am unsure and would like to discuss this further with someone from the medical practice before I sign.

Patient's Name: _____ Date:_____

Patient's Signature: _____

Signed as Guardian for Child:_____

Name: (printed) _____