DR RICHARD LAWSON
PATIENT REGISTRATION

MBBS (HONS 1), FRACS. FAOrthA
HAND, MICRO and PERIPHERAL NERVE SURGEON

PATIENT INFORMATION

Title Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mstr ☐ Dr ☐ Other ☐

Given Name: ☐ Surname: ☐

Must be the same as they appear on your Medicare Card

DOB: ☐

Residential Address: ☐

Suburb: ☐ State: ☐ Post Code: ☐

Postal Address: ☐

Suburb: ☐ State: ☐ Post Code: ☐

Phone: Mobile: ☐ Home: ☐

Email: ☐

Medicare: ☐☐☐☐☐☐☐☐☐☐ Ref: ☐ Expiry: ☐☐ / ☐☐

(No in front of your name)

Health Fund: ☐ Membership No: ☐ Ref: ☐

Type of Cover: *(Please tick)* *Hospital* ☐ *Extras* ☐

DVA Card: Colour: ☐ Number: ☐

Next of Kin: Name: ☐ Phone: ☐

(Required by law)

REFERRING DOCTOR

Name: ☐ Is this doctor a: GP ☐ or a: Specialist ☐

Usual GP: ☐ Suburb: ☐

PARENTS DETAILS (IF PATIENT UNDER 18 YEARS OF AGE)

Given Name: ☐ Surname: ☐

DOB: ☐ Medicare Ref: *(Number in front of parent's name)* ☐

WORKERS COMPENSATION or THIRD PARTY CLAIMS

Worker's Compensation ☐ CTP ☐ Lifetime Care & Support ☐ Public Liability ☐

Has your consultation with Dr Lawson been approved by the Insurance Company? Yes ☐ No ☐

Claim Number: ☐ Date of Injury: ☐

Insurance Company: ☐ Case Manager: ☐

Case Manager Phone/Email: ☐

Employer: ☐ Contact Person: ☐

Contact Person Phone/Email: ☐

Patient Name:

DOB:

Are you:

- ☐ Right hand dominant
- ☐ Left hand dominant
- ☐ Ambidextrous

Occupation:

Please list the names of any people attending with you today:

In your own words, why are you coming to see Dr Lawson:

Other medical problems / previous operations:

Hobbies (including sport, music and other activities):

DR RICHARD LAWSON
PATIENT CONSENT

ACCOUNTS

I agree to pay all accounts rendered by Dr Lawson unless otherwise pre-approved in writing by an insurance company.

REFERRALS

I understand that even though a referral is not required for me to be reviewed, it is a legal requirement to enable me to claim a rebate with Medicare. A GP referral is valid for **12 months** and a specialist referral is valid for **3 months**. It is my responsibility to ensure that my referral is current prior to consultations.

TREATMENT RECOMMENDATIONS BY DR LAWSON

I understand, that I may be referred by Dr Lawson for additional services such as physiotherapy, radiology, pathology and pharmacy. I understand I will consent or not consent to these recommendations at the time of consultation and am responsible for any additional fees that are levied for these services.

An important note regarding physiotherapy- this is a common recommendation for many of our patients. In an effort to maximise convenience for the patient, our office is happy to co-ordinate a joint consultation with Dr Lawson and North Shore Hand Therapy; this will incur fees for both service providers.

COLLECTION OF PERSONAL INFORMATION / PHOTOS

Dr Lawson collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we can properly assist, diagnose and treat illnesses and be pro-active in your health care. We may also use your information in the following ways.

- Administration purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice.

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 that my failure to do so might compromise the quality of health care and treatment given to me.

I am also aware of my right to access the information collected about me, except in circumstances where access might be legitimately withheld. I understand I will be given an explanation in these circumstances. I understand that if I request access to any information about me the practice will be entitled to charge fees to cover time and administrative costs which may not be covered by Medicare rebate.

I consent to the handling of my information by Dr Lawson for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

I understand that Dr Lawson may take photos or videos of me during consultations and/or surgery. These photos/videos will only be used for teaching or research purposes and will not reveal any of my personal details.

Please tick

☐ ***I DO*** *consent to photos/videos being taken of me*

☐ ***I DO NOT*** *consent to photos/videos being taken of me*

SIGNATURE AND ACKNOWLEDGEMENT

I acknowledge that I have read and understood the information as outlined above.

Patient Name: _____

Signature: _____ Date: _____

Of Patient/Parent/Guardian/Power of Attorney (if applicable)