DR MELISSA LUCKENSMEYER
OBSTETRICS • GYNAECOLOGY • FERTILITY
MBBS FRANZCOG

PATIENT DETAILS FORM

Title: _____ Address: _____ DOB: _____

First Name: _____ _____ Phone Numbers

Surname: _____ Suburb: _____ Home: _____

Middle Name: _____ State: _____ P/C: _____ Work: _____

Known as: _____ Country: _____ Mobile: _____

Occupation: _____ Email: _____

Medicare & Private Health Fund Details

Medicare No: _____ Ref. No: _____ Private Health Fund: _____

Expiry Date: _____ Membership No: _____ Ref. No: _____

"Ref. No." above refers to the number in front of your name on your Medicare & Private Health Fund cards.

Partner Details (if applicable)

Name: _____

DOB: _____

Occupation: _____

Contact Number: _____

Emergency Contact Details

Name: _____

Contact Number: _____

To the Patient

Consent to the collection, use and disclosure of personal information by the medical practice operated by Luckensmeyer Medical Pty Ltd (Group)

Please read this document carefully and sign where indicated below.

The Group collects, uses and discloses your personal information 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 and treat you and be pro-active in your health care. By providing your personal information and signing this form you consent to the collection, use and disclosure of your personal information for the following purposes:

- disclosure to other persons or organisations 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;
- on a confidential basis to external service providers so that they can provide medical, financial, administrative or other services in connection with the operation of our services;
- sharing your information within the treatment team of the Group, including any person who collaborates with the Group to provide on-call or locum services on behalf of the Group;
- communicating with referring medical practitioners, referrals to other medical practitioners, hospitals or health providers and referring specimens for analysis;
- disclosure, where legally required, to third parties; including, responding to a court subpoena or for mandatory reporting compliance in respect of the Group's regulatory obligations;
- conveying information to close family members in accordance with the recognised customs of medical practice;
- management, funding, service monitoring, planning, evaluation and complaint handling;
- addressing liability indemnity arrangements including reporting to an insurer or legal representative;
- for matters relevant to public health and safety (including reporting a notifiable disease).

By signing this document you represent that you have read this document and are aware that the Group has a privacy policy on the collection, use and disclosure of personal information. Our privacy policy states in full how we deal with your personal information. A copy of the Group's privacy policy is available on request and the privacy policy can be accessed at any time at the website address http://www.melissaluckensmeyer.com.au. The Group's privacy policy deals with matters such as how your personal information can be accessed and also information regarding how you may complain about a breach of the Australian Privacy Principles. The Group's privacy policy sets out your right to access the information collected about you, except in some circumstances where access might legitimately be withheld. The privacy policy of the Group sets out how you can request access to personal information about you and that the Group will be entitled to charge you fees to cover its costs in meeting that request.

You understand that you are not obliged to provide any personal information requested, but that your failure to do so might compromise the quality of the health care and treatment given to you.

You consent to the use and disclosure of your information by the Group for the purposes set out above, subject to any limitations on access or disclosure that you notify the Group of.

Patient's Name: ..... **Signed:** ..... **Date:** .....