

PATIENT VERIFICATION FORM

We are committed to providing our patients with the best care. To do this it is essential that you please complete all fields of the following **(please ensure that it's clear, well formatted, and easy to read)**.

1. Patient Medicare Card Number:

Patient Number on Medicare Card/UPI:

Patient Full Name as shown on Medicare Card:

Patient Date of Birth (DD/MM/YYYY): **Gender** Male / Female

Patient Address to complete if it's First Visit/ New Booking Appointment or if it's to update it:

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2. Family details

Parent Medicare Card Number (to write if different to the Patient):

Parent Claimant Number on Medicare Card/UPI Claim#:

Parent Claimant Full Name as shown on Medicare Card:

Parent Date of Birth (DD/MM/YYYY): **Gender** Male / Female

Mobile Number: **Email:**

3. For Carers from Organisations. Before Consultation, you must call your Organisation to confirm payment, and if you did attend recent Consultation(s), you must show or send to us the recent proof payment to: info@mykidclinic.com.au, before further consultation(s).

Organization Name: **Address:**

Organization Phone Number: **Email:**

Carer Name: **Phone Number:**

Privacy Statement (collection of information and its use) As a patient of our medical practice, we require you to provide us with your personal details and other relevant information so that it can be registered in our system, assessed and properly treated for your health needs. Your medical record is a confidential document. It is the policy of our practice to always maintain security of personal and health information and to ensure that this information is only available to authorize members of staff. This information is collected in accordance with the national privacy principle and is used to manage your healthcare. If you wish to view a copy of our privacy policy, please ask one of our team members. We require your consent to collect personal information about you and to use the information you provide in the different ways for example **A)** for the use of administrative/ operational purposes of our medical practice, **B)** for building purposes including compliance with Medicare and health insurance Commission requirement, **C)** disclosure to others involved in your healthcare including treating doctors, other doctors, local medical practitioner, registrars, trainees working with our practice, other specialists and allied health practitioner within or outside this medical practice **D)** to comply with any legislative or regulatory requirement for example notifiable diseases or for court summons, **E)** for reminders, letters, SMS and e-mail which may be sent to you regarding your health and management, to participate in research and quality improvement program. **If you are not clear about any information or need further information, please talk to your doctors or practice manager. Sign here to consent to the above:**