SOUTHERN SYDNEY VASCULAR

ABN: 25723363072

Dr Igor Banzic
MD PHD MBBS FEBVS FRACS
Vascular and Endovascular surgeon
Provider# 5557895B

PATIENT DETAILS:

Surname: ……..……**Title:** …….

First Name: ……..……..…… **Middle Name**: …….

Address: ……..…….

Date of Birth: ……

Phone No: …… **Mobile No** : ……..

Email: ……..

Medicare No: ……**Ref No**: ……**Expiry date**: …..….

Name of Private Health Fund: ……..……..……..

Membership Number: ……..……

Pension No: ……..……..…….

Dept of Veteran Affairs card: **Gold/White**……**No**: ……

Work Cover Claim Number ……. Insurer …….

Next of Kin/Contact person Surname: …… Given ……

Contact NO …… Relationship ……..

GP Details: ……Address ……

Any other Medical Practitioners (Specialists you see regularly):
…….....

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➔ **P2**

MEDICAL HISTORY

Do you have or have you had:

High Blood Pressure: …… Diabetes: ……

High Cholesterol: …….. Heart Disease: ……..

Stroke/TIA: …… Lung Disease: ……..…..

Do you Smoke: ……..How many/how often: ……..

Were you previously a smoker: …… When did stop:……

Do you drink Alcohol – Never ……..….Occasional ..…….……..

Daily ……How many drinks: ……...

Allergies: ……

Previous Operations:
……..……

……

……..……

Current Medications (Please write or supply list):
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INFORMATION ABOUT FEES

A GP referral letter is valid for 12 months and a Specialist referral is valid for 3 months Please note this practice does not bulk bill for consultations by the doctors.

First consultation $420.00
Subsequent consultation $ 240.00
For patients holding a current Australian Government Pension Concession Card the rates are discounted to:
First Consultation $285.00 and subsequent consultations $185.00

All Ultrasounds are bulk billed for Medicare eligible patients with a current Medicare card. Patients holding overseas health insurance will be required to settle ultrasound accounts and then claim from their fund as we are unable to directly bill these insurers**.**

By signing this form, you agree that you have read the above information on fees.

Note: Occasionally the Doctor will be delayed by a complex patient. If this does happen, we apologise in advance and thank you for your patience.

SIGNATURE: …… DATE: ……

➔ **P3**

PRIVACY POLICY

Collection of Personal Information, Privacy Act 1988 (Cth) and HRIP Act 2002 (NSW) Amended March 2014

This medical practice collects information from you 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 illnesses and be proactive in your health care. We will also use the information you provide in the following ways:

- Administrative 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
- {delete if not relevant} Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of teaching. Please let us know if you do not want your records accessed for this purpose, and we will note your record accordingly
- {delete if not relevant} Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to opt-out of any involvement

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 the health care and treatment given to me.

I am also aware that this practice has a privacy policy which contains information about accessing and seeking correction of personal information, privacy complaints handling process, and whether the practice is likely to disclose personal information to overseas recipients.

I am 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 information about me, the practice will be entitled to charge fees to cover time and administrative costs which may not be covered by a Medicare rebate.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

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

Signed: ……. Date: ……