



## Patient Registration Form

Please fill out the sections below and send through to our staff via **email [info@qanc.com.au](mailto:info@qanc.com.au)** or **fax 07 5597 6542**.

### Patient Information

*\*Required Fields*

**Child's Name:\***

**Childs Grade:**

**Parents Name:\***

**Parents Phone Number:\***

**Parents Email:\***

### Patient Information

**School Name:\***

**Address:\***

**School Phone Number:\***

**Teachers Name**

**Teachers Email:**



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### Consent & Information

#### Cancellations:

- QANC adheres to a strict Cancellation Policy to minimise waiting times. Cancellations made on the same day as the appointment or non-attendance on the day will incur a cancellation fee of the full consultation cost.
- This fee does not qualify for Medicare Rebate.

#### Fee Payments:

- Fee payment is required at the time of the consultation.
- Payment methods include EFTPOS, credit card and cash.
- A referral from a GP is valid for twelve months. A referral from a Specialist is valid for three months.

In accordance with the Privacy Act (1988), all information collected in this practice is treated as "sensitive information". To protect your privacy, this practice operates in accordance with the Act.

We use the information you provide to manage your health care. You can assist in maintaining the accuracy of your information by advising the practice of changes of address, phone number etc.

Selected information may be disclosed to various other health services involved in providing you health care management, (e.g GPs and other health professionals).

#### Privacy Policy:

Review our privacy policy available on our website at [www.qanc.com.au/privacy-policy/](http://www.qanc.com.au/privacy-policy/)

- I have read and accept the privacy policy.

#### Consent:

- I give consent to QANC to access/disclose my personal health information by obtaining, accessing and/or communicating with my referring doctor and current/past medical providers or relevant services for the purposes of diagnosis, treatment and optimising my medical management as deemed appropriate and in accordance with Ethical and Best Practice Guidelines.
- I agree to the terms of the above consent to access personal health data, cancellation policy, fees and payment policy.

**Signature**

**Date**