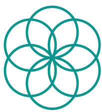


DrMeganByrnes
Obstetrician and Gynaecologist

Joondalup Private Hospital
Suite 10 Specialist Medical Centre East
Shenton Ave, Joondalup, WA 6027

PATIENT DETAILS

Title: Preferred Name: Date of Birth:

Given Names: Surname:

Address:

Suburb: State: Postcode:

Phone

Home: Mobile: Work:

Email: Occupation:

I consent to receive reminders & messages via SMS/Email ☐ Yes ☐ No

NOK/ EMERGENCY CONTACT

Relationship: Name: Phone:

Relationship: Name: Phone:

BILLING AND INSURANCE INFORMATION

Medicare No: Ref No. Expiry:

Private Health Fund: Membership No.

REFERRALS

Referring Dr Name: Date of Referral:

Address: Phone:

Usual GP: Phone:

Address:

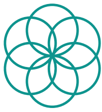
Any other practitioners to be included in the correspondence?

Name: Phone:

Address:

Name: Phone:

Address:



Joondalup Private Hospital
Suite 10 Specialist Medical Centre East
Shenton Ave, Joondalup, WA 6027

PATIENT INFORMATION AND CONSENT FORM

Examination Consent

I understand that many gynaecological conditions may require examination by the specialist. These examinations may include breast, abdominal or vaginal examinations (speculum and/or internal). There may be an indication to perform abdominal or transvaginal ultrasound scans. I acknowledge the above and hereby give consent for such procedures to be performed with the understanding that it is my right to refuse to have an examination cease at any time. I acknowledge that I may request a chaperone to be present for the examination.

Print Name ____________________ Patients Signature ____________________ Date ______________

Use and Disclosure of Personal Health Information Agreement

The following information is about the collection, use, disclosure, security, quality and access of personal information. Please read and then sign below where indicated. This consent form will be added to your medical record.

This practice collects personal information from you, for the primary purpose of providing quality health care. Dr Megan Byrnes will ask you to disclose deeply personal, private and clinically sensitive information to assist in the effective assessment, diagnosis and treatment of your medical condition.

Dr Megan Byrnes and her team are committed to protecting the privacy, the confidentiality and security of any information that you provide to us. We all abide strictly by the Privacy Act.

There are situations where Dr Megan Byrnes and her team are required to use or disclose some of your confidential information. These situations may include but are not limited to;

- Administrative requirements of Dr Megan Byrnes' Consulting rooms
- Billing, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to other health care providers, including pathologists, general practitioners.
- Mandatory reporting under the Child Protection Act 1999
- A court order requiring the release of documents
- Legal requirements about particular health conditions such as diseases with high public health risk
- Debt recovery for services rendered

Patient's Acknowledgement

- I have read the above information and understand why collecting information about me is necessary.
- I am aware that Dr Megan Byrnes's Consulting rooms has a privacy policy in relation to handling and security of my private and confidential patient information.
- I understand that I am not obligated to provide any information requested of me, however my failure to provide information may compromise the quality of health care and treatment provided.
- I have the right to request access to my health record under the Information Privacy Act 2009. I am aware that Dr Megan Byrnes' Consulting rooms may legitimately withhold parts of my health record in some circumstances.
- I authorise the disclosure of my private information by Dr Megan Byrnes' Consulting rooms for the purposes set above, subject to any limitations on access of disclosure of which I will notify Dr Megan Byrnes in writing.
- I authorise my insurance benefits be paid directly to Dr Megan Byrnes. I understand that I am financially responsible for any balance.
- I authorise Dr Megan Byrnes or insurance company to release any information required to process my claims.
- I understand that should any of the information collected about me be used for any purpose, other than set above, my consent will be obtained.

By signing this declaration form I acknowledge that I have read and understood this form and been given the opportunity to obtain further information from Dr Megan Byrnes' staff.

Print Name ____________________ Patients Signature ____________________ Date ______________