FERRERS medical clinic
Website: www.ferrers.com.au

2-4 Wehl Street North
(PO Box 438)
Mount Gambier SA 5290

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ABN 11 049 673 399

PATIENT INFORMATION & CONSENT FORM

Title	**Mr☐ Mrs ☐ Ms☐ Miss ☐**		
Surname:	**First Name**		
Preferred Name:		**Date of Birth:**	
Postal Address:			
Suburb and Post Code:			
Home Phone:	**Work Phone:**		
Mobile Phone :			
Preferred Pharmacy	For Scripts :		
Email Address Home :			
Email Address Third Party	(Employer Name for Workcover Invoices to be emailed)		

- I authorise Ferrers Medical Clinic to contact me on the above phone numbers I have provided.
- If appropriate I authorise Ferrers Medical Clinic to leave a message on the above numbers.
- If I no longer wish to be contacted on this number or any email (or if changes to numbers or emails have occurred) I will advise Ferrers Medical Clinic in writing as to any changes .
- If an email address is given , I authorise for my email address to be used for any correspondence , statements , recalls and reminders as required, and or to send to an employer for the purpose of workcover . I also understand and accept the risks that an email communication sent may not be encrypted , and or if a group home email is given that it may be shared or viewed by other family members with access to that email **

Occupation :		**Cultural Background:**	
Medicare Number & Ref:		**Expiry Date**	
Veterans' Affairs Card :	Gold / White (please circle)	**Expiry Date**	
Pension Number:		**Expiry Date**	
Health Care Card Number:		**Expiry Date**	
Next of Kin:	**NAME:** **PHONE:** **RELATIONSHIP**		
Emergency Contact	(Name and Telephone number of the person we can contact if needed) **NAME:** **PHONE:** **RELATIONSHIP :**		

AUTHORITY TO SHARE INFORMATION WITH A THIRD PARTY

I give Authority for : 1. …… and/or 2. ……
to discuss, or be provided with, the following:

Results/investigations ☐ **Yes** ☐ **No** [initial ……] Appointments ☐ **Yes** ☐ **No** [initial ……]
Discuss/Collect scripts ☐ **Yes** ☐ **No** [initial ……] Account details ☐ **Yes** ☐ **No** [initial ……]

Person financially responsible:	**MYSELF ☐ other ☐ ……..** (provide name) 1. As signed I agree, to comply with the Fee Policy of FMC and understand that noncompliance, or non-payment , will result in restriction to services. I also accept that Cash is not accepted for payments, I must use card for all payments. 2. As signed I agree , if my WorkCover claim is rejected or cancelled the monies owed for visits will be transferred to, and be the financial responsibility of the patient.

PLEASE TICK ***(must be completed)***
☐ **VISITOR - name of current clinic ……**
☐ **UPDATING CURRENT INFORMATION**
☐ **TRANSFERRING FROM ANOTHER CLINIC - name of previous clinic …… ……..**
☐ **NEW BORN**

Do you identify as someone from a culturally and/or linguistic diverse background?

☐ Yes - Please elaborate……

To assist with health initiatives - are you Aboriginal or Torres Strait Islander?
☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal & Torres Strait Islander ☐ No

Signed……(persons over 16 years of age must sign) Date……..

Form Checked by: (Staff to Print name) ..... Date.....

FORM 1 – PATIENT CONSENT- INFORMATION FORM