Patient Registration Info

Brighton Health Clinic for kids

PRIVACY INFORMATION AND CONSENT (for attendance to the clinic)

We require your consent to collect personal information about you and your child. Please read the following information about privacy issues, practice requirements and fees carefully, and consent where indicated on the form.

The Brighton Health Clinic for Kids collects information from you regarding your child for the primary purpose of providing quality health care. We ask you about you and your child's personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your child's' health care needs.

This means we will use the information you provide in the following ways:

- Administration purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclose to others involved in your child's health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in reports or results returned to us following the referrals.
- Disclosure to other doctors in the practice, locums, and medical students and by Registrars attached to the practice for the purpose of patient care and teaching.
- We may also need to communicate with teachers, allied health providers and other professionals involved with your child.
  Please let us know if you do not want your records accessed for these purposes. This will be noted accordingly.
- In an emergency situation where it is in the best interest of your child's health care we would disclose appropriate information if requested to do so.

PARENT/GUARDIAN ACKNOWLEDGEMENT (for attendance to the clinic)

I have read the information above and understand the reasons why this information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

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 my child.

I am aware of my right to access the information collected about my child, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other 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 limitation on access or disclose that I notify the practice of.

I agree to receive clinic's appointment reminders with SMS, email or to link with patient's portal.

I agree to abide by the following practice procedures:

- It is my responsibility to make sure I have a current referral from my G.P. for each visit if I am eligible.
- If I fail to attend an appointment and/or do not give more than 72 hours' notice of my cancellation, I may be charged a non- attendance fee as per clinic's policy.
- My child must be in attendance at all appointments (if not, a Medicare rebate is not claimable)
- I understand that the cost of the consultation is above the Medicare schedule fee (if eligible), which means that I will incur an out-of-pocket expense and I am responsible for payment of all services rendered on my behalf and on behalf of my dependents. I agree to pay the account in full at the time of the consultation.
- To know more about our fees for speech pathology assesments please cotnact our reception.
- I am aware and consent that I am responsible to supervise my children whilst we are attending in the clinic and the clinic is not responsible for any injuries or threats accrued.
- I have read this form before signing it and a member of staff has, at my request, clarified aspects of it that I have not understood.

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DEBIT ACCOUNT AND CREDIT CARD PAYMENT AUTHORIZATION (consent required)

By completing this part you hereby authorize Brighton Health Clinic for Kids to debit your bank account or credit card, for each session on the day of consultation or any other day after of the scheduled appt or to incur any cancellation fees not providing the appropriate notice to the clinic and/or the payment of assesments/reports.

This is permission for the amount to be charged as per our fees described above. Any additional costs for extended sessions or further assessments cannot be charged without confirmation from the client. This authorization does not provide authorization for any additional unrelated debits or credits to your account.

We take automatic payment on the day of consultation or for the payment of the reports and a receipt is issued via email. All credit card payments will incur a surcharge of 1.30% during processing. Kindly note that declined cards may result in an additional processing fee as it will go through an additional process when the attempted card is charged again. You authorize the above named business to charge your bank account or credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services described above, for the session cost or cancellation fees only. You certify and confirm that you are an authorized user of this bank account or credit card.