New Patient Registration

Page 1

Dr Roni Ratner
MBBS (Hons), FRANZCOG
Gynaecologist & Laparoscopic Surgeon

Contact Details

Title: First Name: Last Name:

Preferred Name: D.O.B:

Gender: Mobile Phone:

Home Phone: Work Phone:

Email:

Address

Street:

Suburb: Post Code: State:

Medicare + Health Insurance

Medicare Number: Ref Number: Expiry:

Do you hold a private health insurance policy with hospital cover? ☐ Yes ☐ No

Fund Name: Membership Number:

* Please notify reception if you are within your 12-month waiting period.

For patients under the age of 18

Guardian First Name: Guardian Surname:

Guardian D.O.B: Guardian Mobile Number:

Guardian Medicare Number: Ref Number: Expiry:

Health Team Members

Regular GP Name: Clinic Name:

If you would like other specialists/allied health practitioners to be included in correspondence regarding your medical care please provide their details:

Name: Clinic Name/ Location:

Name: Clinic Name/ Location:

Emergency Contact

First Name: Surname:

Mobile Phone: Relationship:

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Page 2

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Communication Preferences

Do you consent to be contacted for research by our research department? ○ Yes ○ No

Do you consent to be contacted via email and/or mobile phone with regards to results? ○ Yes ○ No

How did you find out about the services of Dr Roni Ratner?

Fee Policy & Privacy Statement

I acknowledge and understand that there is a consultation fee for the services of Dr Roni Ratner and that these fees are payable on the day of consultation. I acknowledge and understand that if a procedure is necessary during my consultation, there may be an associated cost in addition to the standard consultation fee. I acknowledge and understand that failure to attend my scheduled appointments or late cancellations (less than 48 business hours notice) will incur a non-attendance/cancellation fee which is not eligible for Medicare rebates.

I acknowledge and understand that there will be out-of-pocket costs for services provided outside of consultations and that it is my responsibility to confirm with Medicare and/or my Private Health Insurer (if any) as to my eligibility and the amount of reimbursement

Full Name: Signature: Date:

This medical practice (Dr Roni Ratner Pty Ltd) collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal information and medical history so that we may appropriately assess, diagnose and treat your health care needs. This information may be used in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including and not limited to, compliance with Medicare and Private Health Insurance Funds. If an invoice/s remain unpaid after the due date this information and your details may be passed on to a debt collection agency.
- Disclosure to other medical professionals and administrative staff involved in your health care, including treating doctors, specialists and allied health practitioners outside of this medical practice as advised by you.

By signing below I understand the reasons why my information must be collected. I understand that failure to provide this information may compromise the quality of health care and treatment given to me. I understand that if my information is to be used for any purpose other than the above, my consent will be sought.

Full Name: Signature: Date:

☐ ***If you are unable to sign, please tick this box acknowledging the above privacy and fee policy statements.***