ADELAIDE COLORECTAL
+GENERAL SURGERY

Anthony Ciccocioppo
BSc BM BS FRACS
Surgeon
Provider No: 253690TY

Nicholas Rieger
MBBS MS FRACS
Surgeon
Provider No: 039286NH

PATIENT DETAILS:

Dr|Mr|Ms|Miss|Mrs : First Name: _____ **Surname**: _____

DOB: _____/_____/_____ **Gender Identity: Male** ☐ **Female** ☐ **Other** _____(Optional)

Street Address: _____

Suburb: _____ **Postcode:**_____

Telephone: **M** _____ **W** _____ **H** _____

Email Address: _____

Do you identify as Aboriginal ☐ **Torres Strait Island** ☐ **Both** ☐

Occupation: _____ **Religion:** _____

General Practitioner: _____ **GP Phone:** _____

GP Address: _____

Private Health Fund (Hospital Cover): _____ **Member No**: _____

Medicare no: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Ref no:** ____ **Exp date:** _____ / _____

DVA No (if applicable) _____ **Gold / White** (Please Circle)

EMERGENCY CONTACT / NEXT OF KIN

Name: _____ **Relationship**: _____ **Ph:** _____

WORKCOVER CLAIM ☐ **Insurance Company** _____

Claim ID _____ **Claim Manager** _____

Phone _____ **Email** _____

MEDICAL HISTORY

Height (cm): _____ **Weight (kg) :** _____

Do you have any previous illness or medical condition we need to be aware of (tick below)?

□ High blood pressure	□ Angina	□ Diabetes – Type 1 or Type 2
□ Bleeding tendency	□ Stomach Ulcer	□ Asthma
□ Hepatitis	□ Taking blood thinners	□ Currently pregnant …….. Weeks
□ High Cholesterol	□ Deep vein thrombosis	
□ HIV	□ Heart valve/Cardiac surgery	

□ Other – provide relevant details:

Do you have any Allergies? Yes / No (list below)

Are you taking any medications? Yes / No (list below)

Please turn over and complete Privacy Policy and Financial Consent Form

PRIVACY POLICY AND FINANCIAL CONSENT FORM

CONSULTATIONS Medicare does not completely cover the cost of your consultation. There will be an out-of-pocket expense**.**
All fees are payable on the day of your consultation – Eftpos, Credit Card, cheque or Cash payments accepted.

TERMS OF PAYMENT – Patient or Guardian to sign
I understand that medical expenses incurred as a result of consultation with Dr Nicholas Rieger/Dr Anthony Ciccocioppo are my responsibility. I understand that payment in full of the account regardless of any third-Party Claim/Compensation Claim/ Medicare Claim/Private Fund Claim is ultimately my responsibility.

I/We acknowledge that the full payment of consultation fees is my responsibility and are required on the day of consultation.

I/We understand that the Surgeon gap fees for operations and procedures are payable 7 days prior to surgery by Visa/Mastercard, EFT, cash or cheque, if my procedure/surgery is cancelled the gap fee will be refunded in full. The gap payment (the out-of-pocket expense) will depend on the magnitude of the surgical procedure performed. In the event that intra-operative events necessitate a change in the planned procedure, the gap payment may need to be adjusted accordingly.

I/We agree to pay all expenses incurred in pursuing recovery of overdue amounts from me/us, including (but not limited to) legal fees, location administrative costs and any fees payable to debt recovery consultants.

Privacy Policy
We are very serious about your privacy and are committed to handling your information in accordance with the Privacy Act 1988. The law gives you certain privacy rights in relation to information that you give to this medical practice. We need your consent to collect personal information about you. The fact that you have come to our practice implies that you consent to us knowing about your health situation either for a particular event or for your general medical care.
The information we may ask you to give us is very personal. But not having it will restrict our capacity to provide you with a standard of medical care you expect. Giving this information will ensure we provide adequate medical diagnoses and appropriate treatment and medical care.

Collection and Disclosure of Information
The main reason we collect information from you is so we can assess, diagnose, and treat your illness properly and be pro-active in your health care. We will collect your health information directly from you, but in some instances, we may also collect information about you from a third party, for example from other health service providers, a family member or legal guardian. We will also use information you provide us in the following ways:

- Administration of this medical practice
- Billing including compliance with Medicare and Private Health Funds, Hospitals, Anaesthetists and Assistant Surgeons.
- Disclosure to others involved in your healthcare, including doctors and specialists inside/outside this practice who may become involved in treating you. This may be in the form of referral to other medical specialists, requests for medical tests and in the results of reports from these requests. If necessary, we may discuss with you.
- Digital images may be used to record your condition and treatment.

Quality and Security
We will endeavour to ensure that all personal information we collect, use or disclose is accurate, complete and up-to date. If your details change or you believe our records are not up to date and/or accurate, please contact us.

Access to Health Information
You have a right to have access to the health information that we hold in your health record. We will grant access unless the Privacy Act 1988 or other relevant law allows us or requires us to refuse such access. We may charge a fee to recover reasonable costs associated with supplying information to you. If you would like to access your personal information, please contact our Practice Manager on 8362 0887 or email contact@adelaidecolorectal.com.au

Patient Consent
I have read and understand this form and give my consent to Dr Nicholas Rieger/Dr Anthony Ciccocioppo and staff of this Practice to use and disclose my personal health information for the purpose of providing the highest quality and continuity of health care.
I am aware that this practice has a privacy policy on handling of patient information.
I understand that I am not obliged to provide any information requested of me and I also understand that failure to provide all the information needed may restrict the ability to provide the quality of health care and treatment that I expect.
I am aware that I have the right to access the information collected about me, except in circumstances where access might legitimately be withheld. I understand I will be given explanation in these circumstances.
I understand that if my information is to be used for any other purpose other than set out above, further consent will be obtained.
I consent to the handling of my information by this practice for the purposes set out above.
I acknowledge that I have read this form and a member of staff from this practice at my request clarified any aspects that I did not first understand.

I acknowledge that I have read and agree to the terms and conditions set out on both sides of this form.

Patient/Guardian Name_____ Signature: _____
Date: _____/_____/_____