RETINOLOGY INSTITUTE

New patient registration form and information

Please allow 90 - 120 minutes for your appointment. Extra time may be required if further diagnostic tests or minor procedures are performed on the day. We recommend that you do not drive, and have a carer with you as your vision may be blurred from dilating eye drops.

PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT:

- A valid referral.
- Your current glasses.
- A list of all information about your medical history, significant health problems or previous operations.
- A list of all current medications, including eye drops, injections or tablets.
- A list of all allergies to all medications.
- Details of relevant family history.

All fees are applied at the discretion of the treating Ophthalmologist.

	PRIVATE			PENSION		
	Fee	**Rebate**	**Gap**	**Fee**	**Rebate**	**Gap**
New Patient / New Condition	**$285.00**	**$81.30**	$203.70	**$257.00**	**$81.30**	$175.70
Review	**$122.00**	**$40.85**	$81.15	**$110.00**	**$40.85**	$69.15
Initial OCT**	**$190.00**	**-**	$190.00	**$171.00**	**-**	$171.00
Review OCT**	**$71.00**	**-**	$71.00	**$64.00**	**-**	$64.00
Intravitreal Injection	**$589.00**	**$281.40**	$307.60	**$531.00**	**$281.40**	$249.60
Angiogram	**$491.00**	**$142.25**	$348.75	**$442.00**	**$142.25**	$299.75
Laser	**$727.00**	**$422.00**	$305.00	**$655.00**	**$422.00**	$233.00
Field Test	**$255.00**	**$63.50**	$191.50	**$230.00**	**$63.50**	$166.50

**** Ocular Coherence Tomography:** Please note that this diagnostic imaging test is conducted for all appointments.

Diagnostic Tests and Minor Procedures: These may be required by your Ophthalmologist on the day and offer immediate treatment and management of your condition. Additional fees are charged for these tests and procedures. Some of these fees are not claimable from Medicare. We will endeavour to inform you of these fees on the day. Please ask our staff if you would like more information on these costs at the time they are being performed. In the unlikely event that your account is referred to a debt collection agency or solicitor, you agree to pay the additional fees incurred in the collection of the debt.

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RETINOLOGY INSTITUTE

New patient consent and information

Surgery Quotes: We will provide a full estimation of costs and details for all surgery bookings.

Failure to Attend/Cancellation within 24 hours of Appointment Fee: Standard consultation fees may apply for cancellations and changes within 24 hours of scheduled appointments, and for failing to attend your appointment.

PATIENT INFORMATION

In order to provide you with the highest standard of medical care, Retinology Institute is required to collect personal information about you (or your child / dependent). Your personal health information will be used for administrative purposes to assist in the running of Retinology Institute including, disclosure to others involved in your healthcare, such as treating doctors and specialists within and outside this Medical Practice. This may occur through referral to other Doctors, or for medical tests and in the reports or results returned to your doctor following referrals.

Retinology Institute participates in research, professional development, and quality assurance/improvement (QA) activities from time to time, to improve individual and community health care and practice management. At times de-identified information (anonymous) may be collected about you for the purpose of research and clinical audits. At times we may request the presence of a third party to be present during your consultation. This may include an Orthoptist, Optometrist or other health professionals. Your further consent will be requested prior to any other third party being invited to attend your consultation.

CONSENT

By signing this form I acknowledge that Retinology Institute will collect and store personal health information about me (and my child(ren) if applicable). This information may be shared with other health professionals for the sole purpose of enhancing your whole health care needs. I give my consent to be part of the Practice's, National, and State recall and reminder systems.

By signing this form I agree to the above and understand that I may withdraw my consent at any time:

Name: _____ **Signed:** _____

Date: _____/_____/_____

PERSONAL DETAILS **Title: Dr/Mr/Mrs/Ms _____**

Given Name:	**Surname:**
Known Name:	**Date of Birth:**
Address:	
Suburb:	**Postcode:**
Phone Number:	**Mobile:**

May we use SMS to communicate with you regarding your appointment? ***YES*** *|* ***NO***

If 'No', do you have a carer or relative that we can SMS your next appointment time? ***YES*** *|* ***NO***

If 'Yes' please provide their details in the emergency contact or next of kin section below.

Email:

May we use email to send you correspondence or communicate with you regarding your appointment? ***YES*** *|* ***NO***

Occupation:

Ethnicity: Australian | Aboriginal | Torres Strait Islander | Other _____

EMERGENCY CONTACT

Name:	**Relationship to patient:**
Contact Number:	**Email:**

NEXT OF KIN (if different to above)

Name:	**Relationship to patient:**
Contact Number:	**Email:**

BILLING DETAILS

Medicare Number:	**Patient Number:**	**Expiry Date:**
Pension Card:	**Expiry Date:**	
Healthcare Card:	**Expiry Date:**	
Veteran Affairs VX Number:	**White/Gold:**	
Private Insurance Health Fund:	**Membership Number:**	

TAC

Date of Accident:	**Claim Number:**

WORKCOVER

Insurance Company:	**Claim Number:**
Claim Manager Name:	**Claim Manager Contact:**

GENERAL PRACTITIONER

Name:	**Practice Name:**
Address:	**Phone Number:**
Email:	**Fax Number:**

OPTOMETRIST

Name:	**Practice Name:**
Address:	**Phone Number:**
Email:	**Fax Number:**

Do you have any other medical specialists involved with your care? **(e.g. Cardiologist, Endocrinologist etc.)**

Name:	**Practice Name:**
Address:	**Phone Number:**
Email:	**Fax Number:**

Do you consent to a report and/or medical information on your condition being sent to the providers above? ***YES | NO***

MEDICAL HISTORY - Please list any significant health issues and allergies