Title:	**Surname:**	**First Name:**	
Middle Name:		**Date of Birth:**	
Address:			
Home Phone:	Mobile:	Work Phone:	
Email:			
Next of Kin:	Name:	Best contact Number:	
Usual GP		Name of Clinic	
Medicare No:	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref ___ (No. next to your name) Expiry Date: ___ / _____		
Private Health Insurance	Name of Fund	Membership Number	
If applicable	DVA of Pension/Concession Card Number:	Expiry:	

ALL PATIENTS: Please complete and sign this authority.

Personal Information and Health Record Access & Informed Financial Consent

Our staff are bound by strict legal duty of confidentiality. We maintain strict policies and practices with respect to who has access to personal information about you. Information will generally be collected from you and your general practitioner. In some circumstances we might need to access personal information and health records from another health facility about your diagnosis and treatment.

We will generally provide information about your care to your doctor and other specialists involved, and any special instructions related to your care.

I consent to the collection, use and disclosure of my personal information in accordance with the I**nformation Privacy and Other Legislation Amendment Act 2023 (IPOLA Act) and Queensland Privacy Principles (QPPs).**

INFORMED FINANCIAL CONSENT

We have a commitment to ensure that you are informed about your financial obligations. Depending on your health cover or insurance you may be responsible for a range of out-of-pocket costs.

Dr Popovic is a "Known Gap Provider", which means that you may have an out-of-pocket expense for your surgical procedure provided by Dr Popovic. The maximum out of pocket expense that you will be charged per procedure/item will depend on your Health Insurance Fund.

This does not cover services provided by other doctors, such as anesthetist, surgical assistant, pathologist, or other costs associated with the procedure.

I understand that it is my responsibility to confirm with my health insurance fund the level of cover that I have. We are obliged to obtain your consent to acknowledge that you understand, please complete the 'Informed Financial Consent' below.

I agree to pay any additional costs associated with my procedure/hospital admission.

I, (Name)_____ am aware that there will be a fee of $160 (Medicare Rebate $86.15) charged for my telehealth (video) consultation and I consent to the collection, use and disclosure of my personal information in accordance with **the Queensland Privacy Principles (QPPs).**

Signed: **Date:**