Soul Speech Pathology - Privacy Policy

ABN: 33 654 854 609
Clinic Location: Suite 5/12 Alma Road, New Lambton NSW 2303 (Access Via Cromwell Street)
Phone: (02) 4942 1516
Email: info@soulspeech.com.au

Soul Speech Pathology needs to collect information about you/your child for the primary purpose of providing a quality service to you/your child. In order to thoroughly assess, diagnose and provide therapy, we need to collect some personal information from you (about your child). If you do not provide this information, we may be unable to treat you/your child. This information will also be used for:

a. The administrative purposes of running the practice;

b. Billing either directly or through an insurer or compensation agency;

c. Use within the practice if passing your case to another speech pathologist within the practice for your/your child's ongoing management;

d. Disclosure of information to your/your child's doctors, other health professionals or to teachers to facilitate communication and best possible care for you/your child; and

e. In case of insurance or compensation claim, it may be necessary to disclose and/or collect information that affects your return to work.

We do not disclose your information to overseas recipients.

To ensure the process of quality treatment provision, information about you/your child's assessment results and progress may be given to relevant service providers who are involved in your/your child's management. These may include your/your child's doctor, teachers, specialists, insurers, solicitors, employers or others, but only when it is considered to be of benefit to your/your child's progress. Please provide names of individuals involved in your/your child's care.

Please list the names and contact details of the individuals involved in your/your child's care:

_____

_____

_____

_____

I _____ (*name*), have read the above information and understand the reasons for collecting the information and the ways in which the information may be used. I understand that it is my choice as to what information I provide and that withholding or falsifying information might act against the best interests of my/my child's assessment and therapy progress. I am aware that I can access my/my child's personal and treatment information on request and if necessary, correct information that I believe to be inaccurate. I understand that if, in exceptional circumstances, access is denied for legitimate purposes, that the reasons for this and possible remedies will be made available to be. I understand that the Practice must obtain additional consent if the information collected is to be used in any other ways other than outlined above.

Client/Parent Name: _____ Client Name:_____

Signed: _____ Date: _____