# Dr Susan Shedda

MBBS FRACS MPH

**Colorectal Surgeon**

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## REGISTRATION FORM

**Title: Mr Mrs Miss Ms Dr M Other _____**

**Surname _____ First Name _____**

**Address _____**

**_____ Postcode _____**

**Telephone: (H)_____ (W)_____ (M) _____**

**Date of Birth _____ / _____ / _____ Email _____**

**Occupation _____**

**Next of Kin _____ Relationship _____**

**Address _____ Telephone _____**

**Medicare No. _____ Ref No. _____ Exp date ____/_____**

**Do you have private health insurance? Yes No**

Health Fund _____ Policy Number _____

Level of Cover _____ Year Joined _____

**Do you have a Veteran Affairs' Card? No Yes -** Gold/White **VX No.: _____**

**Is your account Workcare or TAC related? Yes No**

Company responsible for your account _____

Address: _____

Phone No. _____ Date of Injury ____ /____ /___ Claim No. _____

**General Practitioner: _____**

Address:_____Phone: _____

**Current Medications and Dosages No /Yes**

_____

_____

**Allergies No /Yes**

_____

**** Please complete reverse side of this form**

# Dr Susan Shedda – Colorectal Surgeon

## Privacy Information and Consent Form

We require your consent to collect personal information about you. Please read the following information carefully and sign where indicated below.

The primary reason for gathering your information is to provide you with quality health care so that we can diagnose, treat you and promote your health. This means that we will utilise your information in the following ways:

1. Administrative purpose for the practice.
2. Billing purpose including compliance with Medicare.
3. Disclosure to others involved in your health care, including treating doctors beyond this medical practice and accessing your previous health information. This may include referrals to other health practitioners or for further tests.
4. Disclosure for research and quality assurance activities to improve both the individual and community health care. You can discuss this with the practitioner.

I understand that I am not obliged to provide any information requested from me. I also understand that failure to provide information may restrict the ability of the practice to provide quality health care.
I have read the information above and understand why my personal information must be collected and that the practice has a privacy policy for dealing with patient information.

I consent for the practice to use my information listed above, subject to any limitations on access or disclosure which I notify the practice about.

I do not agree to: _____

**Interpreters**

If you require an interpreter, we require at least one weeks' notice to arrange this service. We only allow medically qualified interpreters. We do not allow interpreters to translate consultations over the telephone. If the interpreter is unable to attend the appointment an alternate appointment will need to be arranged. Whilst we welcome family members to attend appointments, please note they will not be qualified to act as an interpreter if the patient does not understand English.

There may be additional charges for procedures undertaken at the time of the consultation. Patients accept full liability of payment of all accounts incurred including Workcover and TAC claims, which are rejected. In the event where an overdue account is referred at a collection agency or solicitors, the patient will be liable for all legal costs and commission arising.

**Cancellation / No Show Policy**

We understand that unexpected issues arise and that you may not be able to attend your appointment. However, we request that you cancel your scheduled appointment by phone at least 24 hours in advance so that we can fill that appointment time with someone else.

***If an appointment is not cancelled at least 24 hours in advance you may be charged a $50 cancellation fee –*** *this will not be covered by Medicare or your private health insurance.*

**Scheduled appointments**

Should you arrive late for your appointment, Dr Shedda will endeavour to still see you, however if you are going to be more than 15 minutes late, your appointment will need to be rescheduled. If Dr Shedda is running late, we will attempt to contact you to let you know. Alternatively, please feel free to contact us 30 minutes prior to your appointment to see if she is running on time.

***Please note:***

**In order for us to provide the best possible care for you, if you need to bring your baby or toddler to your appointment, you will need to bring another adult to care for your child during your appointment otherwise your appointment may need to be rescheduled.**

*Our aim here is to open otherwise unused appointments for our patients, not to collect missed appointment fees. Your cooperation and consideration is appreciated as we institute this policy.*

**By signing this form you accept the above**

Signature: _____ on ____ / ____ / ____

Signed by (Print Name): _____

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**ADVANCED CARE DIRECTIVE (if applicable)**

If you have an appointed Medical Treatment Decision Maker please complete the details below:

Name: _____ Relationship: _____

Address: _____

Phone: _____Mobile: _____