DELTA DERMATOLOGY

# PATIENT REGISTRATION FORM

We need to collect information that is necessary to properly advise and treat you. This information may include but not be limited to your personal details, medical history and contact details. You will be given our "Patient Consent for the collection, use and disclosure of information" form which explains this more fully.

## PERSONAL DETAILS

TITLE Mr Mrs Ms Miss Other (please specify)

SURNAME

FIRST NAME MIDDLE NAME

DATE OF BIRTH

STREET ADDRESS

SUBURB and POSTCODE

HOME TELEPHONE No.

WORK No.

MOBILE TELEPHONE No.

EMAIL ADDRESS

OCCUPATION If retired, previous occupation:

**My preferred means of contact:**

**Telephone:** ☐ **Home** ☐ **Work** ☐ **Mobile** ☐ **SMS** ☐ **Email** ☐

## ACCOUNT DETAILS

MEDICARE No. REF No. expiry date:

NAME HEALTH FUND MEMBERSHIP No

PENSION CARD No. EXPIRY DATE

HEALTH CARE CARD No. EXPIRY DATE

DVA CARD No. COLOUR

MY HEALTH RECORD IHI No Consent to upload to My Health Record
Yes ☐ No ☐

## NEXT OF KIN

Consent to release health information to Next of Kin: Yes ☐ No ☐

TITLE Mr Mrs Ms Miss Other (please specify)

SURNAME FIRST NAME

RELATIONSHIP EMAIL ADDRESS

HOME PHONE No. MOBILE No.

ADDRESS

## EMERGENCY CONTACT WHO DOES NOT LIVE WITH YOU

Consent to release health information to Emergency Contact: Yes ☐ No ☐

TITLE Mr Mrs Ms Miss Other (please specify)

SURNAME FIRST NAME

RELATIONSHIP EMAIL ADDRESS

HOME PHONE No. MOBILE No.

ADDRESS

Please turn over

## MEDICAL HISTORY PAST AND PRESENT

Do you suffer from or have you ever suffered from:

| | Yes | No |
|---|---|---|
| Diabetes | | |
| Asthma | | |
| Hepatitis | | |
| Stroke | | |
| HIV / AIDS | | |
| Arthritis | | |
| Epilepsy | | |
| Indigestion | | |
| Psychological issues | | |

| | Yes | No |
|---|---|---|
| High Blood Pressure | | |
| Heart Problems | | |
| Faints / Fits | | |
| Bruise / Bleed Easily | | |
| Thyroid Problems | | |
| Chest Problems | | |
| Kidney Problems | | |
| Anaemia | | |

| | Yes | No |
|---|---|---|
| Breathlessness | | |
| Palpitations | | |
| Rheumatic Fever | | |
| Tuberculosis | | |
| Glaucoma | | |
| Reflux | | |
| Ulcer | | |
| Are you pregnant? | | |

Are you a: current smoker / former smoker / never smoked (please circle response)

How much alcohol do you consume in a week? nil / 1-2 glasses / 3-5 glasses / 6-10 glasses / more (please circle response)

Height: …… Weight: ……

List any previous surgery

Do you have any other medical conditions? (please specify)

Do you have any allergies? (please specify)

Have you had any other cancer previously? (If yes please specify)

Is there any history of cancer in your family? (please specify)

What are your concerns to discuss with your dermatologist?

| WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?<br>Please advise of any blood thinners (eg. Warfarin, Plavix, Clopidigrel & low dose thinners such as Aspirin, Cartia or Astrix) | | |
|---|---|---|
| Name of Drug | Strength | How often each day |
| | | |
| | | |
| | | |
| | | |
| | | |

GP: _____Address:_____

Phone no: _____

Other doctors involved in your care: _____

_____

Print Name: _____ Sign: _____ Date: _____

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admin@deltadermatology.com.au

# Delta Dermatology
# Privacy Policy

## Introduction

We are committed to protecting the privacy of patient information and to handling your personal information in a responsible manner in accordance with the Privacy Act 1988 (Cth), the Privacy Amendment (Enhancing Privacy Protection) Act 2012, the Australian Privacy Principles (APP) and relevant State and Territory privacy legislation (referred to as privacy legislation).

This Privacy Policy explains how we collect, use and disclose your personal information, how you may access that information and how you may seek the correction of any information. It also explains how you may make a complaint about a breach of privacy legislation.

This policy is current from September 2020. From time to time we may make changes to our policy, processes and systems in relation to how we handle your personal information. We will update this Privacy Policy to reflect any changes. Those changes will be available for you in the practice.

## Delta Dermatology and what do we do

Delta Dermatology is a private medical practice that specialises in general, vulval and paediatric dermatology.

## Collection of your information

We collect information that is necessary and relevant to provide you with appropriate medical care and to manage our medical practice. This information may include your name, address, date of birth, gender, health information, family history and contact details. This information will be stored on our computer medical records system.

Wherever practicable we will only collect information from you personally. However, we may also need to collect information from other sources such as general practitioners, treating specialists, radiologist, pathologist, hospitals, other health care providers and My Health Record to assist in your medical care.

We collect information in various ways such as over the telephone, in writing, in person in our rooms at Kingsford or over the internet if you transact with us online. This information may be collected by medical and non-medical staff.

There are instances where photographs may be collected as part of your treatment and stored.

In emergency situations we may also need to collect information from your relatives or friends.

We may be required by law to retain medical records for certain periods of time, depending on your age at the time we provided services.

## Dealing with unsolicited information

If we receive personal information that Delta Dermatology did not solicit, we will determine whether it could have been collected in the usual way and if not then it will be destroyed in accord with the APP.

## Anonymity and pseudonymity

Wherever it is lawful and practicable you have the option to request that we deal with you under a pseudonym or anonymously. However, it may be necessary for us to collect your personal or sensitive information for your health care treatment. If you choose to withhold the information we require, we may not be able to provide the treatment you require.

## Security of your information

We take reasonable steps to protect your personal and sensitive information held by us from misuse, interference, unauthorised access, modification, loss or disclosure. This includes during storage, collection, processing, transfer and destruction of the information.

Information is stored in secure electronic databases. Employees and clinical staff of Delta Dermatology, any contracted third parties and other parties to whom we disclose your information sign a confidentiality agreement that requires them to comply with the Privacy Act and our Privacy Policy.

When we no longer require your personal information we will take reasonable steps to destroy the information or ensure that the information is de-identified.

## Use and Disclosure of your information

We will treat your personal information as strictly private and confidential. We will only use or disclose it for purposes directly related to your care and treatment or in ways that you would reasonably expect that we would use it for your ongoing care and treatment. For example, the disclosure of histopathology results to your referring doctor or requests for diagnostic testing. We may also disclose your personal information in accordance with a Patient Consent for Collection, Use and Disclosure of Information form where you have completed one.

We may disclose information about you to outside contractors to carry out activities on our behalf, such as an IT service provider, solicitor or debt collection agent. We impose security and confidentiality requirements on how they handle your personal information. Outside contractors are required not to use information about you for any purpose except for those activities we have asked them to perform.

We will not use your information for another purpose unless you have given consent or one of the exceptions under the Privacy Act applies. For example, if the use of the information is authorised by Australian law or is necessary for law enforcement by an enforcement body.

## Data Quality and Security

We will take reasonable steps to ensure that your personal information is accurate, complete, up to date and relevant. For this purpose, our staff may ask you to confirm that your contact details are correct when you attend a consultation. We request that you let us know if any of the information we hold about you is incorrect or out of date.

Personal information that we hold is protected by:

- Securing our premises
- Placing passwords and varying access levels on databases to limit access and protect electronic information from unauthorised interference, access, modification and disclosure; and
- Locked premises for the storage of physical records.

## Corrections

If you believe that the information we have about you is not accurate, complete or up-to-date, we ask that you contact us in writing (see contact details below).

## Access to Your Medical Record

You are entitled to request access to your medical records. We request that you put your request in writing and we will respond to it within a reasonable time.

There may be a fee for the administrative costs of retrieving and providing you with copies of your medical records.

We may deny access to your medical records in certain circumstances permitted by law, for example, if disclosure may cause a serious threat to your health or safety. We will always tell you why access is denied and the options you have to respond to our decision.

## Sending Data Overseas

The policy of SMSO is to not send your information overseas. The exceptions to this would be if you requested it sent or if deemed necessary in your treatment where we would obtain your consent.

## The Spam Act 2003

The Spam Act 2003 prohibits sending unsolicited emails, SMS and MMS messages for commercial purposes. Unsolicited communications are ones that do not directly relate to a service you have previously signed up with or agreed to.

It is our policy that all electronic communications will include an unsubscribe facility.

Delta Dermatology will send appointment and referral reminders via SMS. If you do not wish to receive communication via SMS you may opt out by advising the practice.

## Complaints and enquiries

Delta Dermatology is committed to the protection of your privacy. If you have any questions about how we handle personal information, would like to complain about how we have handled your information or would like further information about our Privacy Policy, please submit a written query or complaint as outlined below. We will address your complaint and liaise with you to resolve the issue within a reasonable time (usually two weeks). If you are unhappy with the outcome you may lodge a complaint with the Australian Information Commissioner to review www.oaic.gov.au/individuals/how-do-i-make-a-privacy-complaint for further information.

## Contact details

**Please direct any queries, complaints, requests for access to medical records to our administrative team who will escalate the matter as required to the Principal Practitioner:**

Delta Dermatology
97 / 1 Meeks Street
Kingsford 2032

Email: admin@deltadermatology.com.au
Phone: 02 9184 3916
Fax: 02 9475 0507

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# PATIENT CONSENT FOR COLLECTION, USE AND DISCLOSURE OF INFORMATION

This consent form lists what information will be collected, used and disclosed. Please read and tick the boxes which indicate that you give your consent.

If you choose not to consent or not to consent to certain items, please advise the staff or your clinician. Your treatment may be affected if you do not allow the collection or use of information.

Please read the Privacy Policy for an explanation of how and why your information will be used. If you have any questions please ask the staff.

| Tick to consent | |
|---|---|
| | I have read and understood the Privacy Policy of Delta Dermatology in relation to the collection, use and disclosure of my personal information. |
| | I understand that I am entitled to access my own health records except where access would be denied as per the Privacy Act. I also acknowledge that there may be an administrative fee for the preparation of the record. |
| | If I have any questions about this consent form, or if at any time I wish to discuss the use of my information, I understand that I can contact the Delta Dermatology Privacy Officer. |
| | I consent to receive SMS appointment reminders, SMS recalls and other test reminders. I understand that I can opt out by contacting Delta Dermatology. |
| | I give my consent for my clinical care team to correspond to other health care providers via email for treatment and care purposes. I understand that email may not be secure. |
| | I understand that my contact details may be given to a debt collection agency in the event of an overdue account. |

PATIENT NAME: _____DOB: _____

(please print)

SIGNATURE: _____DATE: _____

WITNESS NAME: _____SIGNATURE: _____

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# PATIENT CLINICAL PHOTOGRAPHY CONSENT FORM

In the course of receiving treatment at Delta Dermatology we may request to take photographic or video records. Any photo or video taken as part of your treatment will become part of your medical record and as such will be protected in line with Delta Dermatology's privacy policy and the consents contained on this form.

PATIENT NAME: …… DOB: ……

I understand this consent relates to all medical images and/or video being made of me or my child/dependant, not limited to one date of service. I understand that duplicates may be made for my referring doctor.

| I understand and consent to the use of these photographs/video for the following purposes (please tick according to your preferences). | YES | NO |
|---|---|---|
| **Consent for photo/video records to be used for my own treatment** | | |
| For monitoring, diagnosis and treatment of dermatological conditions I may have or develop | | |
| **Consent for photo/video records to be used for educational, research and awareness purposes** | | |
| For teaching of health professionals by way of printed or electronic means such as in educational presentations to other dermatologists, dermatology registrars, general practitioners, medical students, nurses, pathologists and the like. | | |
| For research publication to increase health professional awareness and education of dermatological conditions (e.g. in medical journals, electronic publications or information booklets). | | |
| For general publication to increase patient awareness and education of dermatological conditions (e.g. patient education brochures, electronic publications, and online educational articles and social media posts). | | |

I acknowledge that:

- I have read the above information and have received an explanation about what clinical photographs will be taken and why.
- I am not obliged to agree to photography or video being taken for my own treatment however if I do not consent this may impact on the quality of treatment that can be provided to me.
- I am not obliged to agree to photography or video being taken for educational, research or awareness purposes and if I do not consent this will not directly impact on the quality of my treatment.
- I understand that my photographs will not be used for any purpose other than set out above without my consent.
- I understand that I am free to withdraw my consent to the above purpose at any time, although in the case of images used for educational, research or awareness it may be impossible to totally remove these from public viewing.
- I understand that where possible photos will be de-identified, however this may not be possible in many situations.

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PATIENT / PARENT / GUARDIAN SIGNATURE:_____DATE: _____

PATIENT / PARENT / GUARDIAN NAME (printed): _____

PATIENT ADDRESS_____ PT DOB _____

DOCTOR SIGNATURE: _____DATE: _____

DOCTOR NAME (printed): _____