Pivotalhealth

NEW PATIENT INFORMATION

Drugs of Addiction Policy

It is practice policy not to prescribe restricted or controlled drugs to new patients

Examples of these drugs include:

Tranquilizers (e.g. Valium), Sleeping Tablets (e.g. Temazepam) or Pain Killers (e.g. Panadeine Forte, Endone etc.)

Requests for such prescriptions will be refused

Billing Policy

Normal Hours

Consultation Type	Standard Fee	Medicare Rebate	Out of Pocket Fee
Standard Consult	$102.00	$45.05	$56.95
Long Consult (20-30 min)	$197.00	$87.10	$109.90
Prolonged Consult (>40min)	$299.00	$128.35	$109.90

* Saturdays incur a $10 surcharge

*Medicare rebate can be processed in real time at the time of payment through our Tyro facility.

WorkCover patients without a claim number

New WorkCover patient claims will need to be paid for by the patient at the time of consultation. Once a WorkCover claim has been approved and assigned a claim number, any subsequent appointments will be forwarded direct to WorkCover for payment.

After Hours

This practice is supported by the Hello Home Doctor Service for the provision of after-hours medical treatment and care for our patients. Patient reports and summaries of treatment will be returned to your treating doctor at the practice.

Privacy Policy

Our practice uses a reminder system to help maintain your health. The practice may send reminders by post, SMS or telephone call for services such as cervical screening, vaccinations, follow up results etc. Our practice also sends information to the Australian Childhood Immunisation Register and Cervical Screening Register. These registers may also send reminders.

This practice is committed to maintaining the confidentiality of your health information and has protocols in place to safeguard your privacy. All information and medical records are strictly confidential and will not be shared with any third party without your consent. For more information on privacy please obtain a copy of our Privacy Policy from reception or our website.

Use of Artificial Intelligence (AI) Consent

Our practice may use secure and regulated Artificial Intelligence (AI) technologies to assist clinicians and administrative staff in delivering high-quality healthcare. This may include supporting clinical documentation, improving administrative efficiency, and assisting with practice operations.

Any AI tools used operate under strict privacy and confidentiality requirements and comply with applicable Australian privacy laws, including the Privacy Act 1988 (Cth). Your personal and health information will only be used for purposes directly related to your care and will be handled in accordance with our Privacy Policy.

AI is used as a support tool only and does not replace clinical judgement. All diagnoses, treatment decisions, and medical advice are reviewed and made by qualified healthcare professionals.

By signing this form, you acknowledge and consent to the practice using regulated AI tools as part of healthcare delivery and administrative processes. Consent may be withdrawn at any time by notifying the practice.

Please turn over the page to fill in New Patient Registration Form

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OPEN 5 DAYS A WEEK

NEW PATIENT REGISTRATION

Mr/Mrs/Ms/Miss/Dr Surname: ..... **Given Name:** .....

Middle Name:.....**Preferred Name:**.....**Date of Birth:** .....

Birth Sex: Male / Female / Other **Gender Identity**.....**Preferred Pronouns**.....

Country of Birth: Australia ☐ **Other**: .....

Do you Identify as: Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ N/A ☐

Ethnicity: .....

Address: ....

Suburb: ..... **Postcode:** .....

PHONE: Home: ..... Work:..... **Mobile**: .....

Email Address: ..... **Occupation**: .....

Medicare Number:☐☐☐☐ ☐☐☐☐☐ ☐ Ref: ☐ Exp: .....

Pension/ Health Care Card ☐☐☐ ☐☐☐ ☐☐☐ Exp:.....

Private Health Insurer (including OSHC) ..... **Private Health Number** .....

Veteran Affairs No: ..... Gold Card ☐ White Card ☐ Exp: .....

Next of Kin* (Mandatory)

Surname ..... Given Name.....Phone No:.....Relationship:.....

Emergency Contact* (Mandatory)

Use Next of Kin? Yes ☐ No ☐

Surname ..... Given Name.....Phone No:.....Relationship:.....

Consent to be notified by SMS: Appointments ☐ Clinical Communication (Results & Clinical Messages) ☐

Clinical Reminders ☐ None ☐ **Opt Out of De-Identified Data Extraction** ☐

How did you hear about us?: *(Please Circle)* Word of Mouth / Recommendation, Facebook, Google, Walking Past, Flyer,

Other (specify)? .....

Please sign below to acknowledge that the information provided above is correct and that you are aware of our Practice Privacy Policy, Practice Drugs of Addiction Policy, and Practice Billing Policy.

Patient's Signature: ..... **Date**: .....

We are constantly looking for ways to improve our service. If you have any feedback for us, please email us at reception@pivotalhealth.com.au

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This information is used to assist us in providing your care, however if you feel uncomfortable answering certain questions you may leave them blank or discuss them directly with your doctor.

GENERAL HEALTH			
SURNAME		**FIRST NAME**	
D.O.B			
HEIGHT	cm	**WEIGHT**	kg
ALLERGIES			
ALLERGIC REACTIONS			

Have you ever, or are you currently being treated for any medical conditions?	Yes	No
Details:		

Have you ever smoked?	Yes	No	If yes, how many per day?	
If you are an ex-smoker, when did you stop?				
Do you consume alcohol?	Yes	No	Occasionally	
How many days per week?			How many standard drinks per day?	
Do you take any other substances/supplements?			Yes	No / Occasionally
Are your Mother & Father alive and are you adopted?			Yes	No / Occasionally

Have you or any member of your family ever had a history of (please tick)

Disease	Yourself	Father	Mother	Other:
Diabetes				
Heart Disease				
Stroke				
Asthma				
Cancer				
Mental health				
Thyroid disease				
Arthritis				
Other:				

WOMEN'S HEALTH		
When was your last pap smear?	Date (if known):	/ /
o Within 12 months	o Within 2 years	o Over 2 years ago:
o Over 4 years ago:	o Never:	o Not required:
When was your last Breast check?	Date (if known):	/ /
o Within 12 months	o Within 2 years	o Over 2 years ago:
o Over 4 years ago:	o Never:	o Not required:
Is there any other information that you feel is relevant to your care?		
If yes, please tell us here:		

MEN'S HEALTH	
Gentlemen over 50, when was your last prostate exam?	Date (if known): / /

MEN'S HEALTH	
Over 50's, when was your last bowel screen?	Date (if known): / /

CLINICAL INFORMATION	
Current Medication(s) & Dosage	
Medical Condition(s) **e.g diabetes**	
Operations & Date(s)	
Major injuries & Date(s)	