Infinity Health	**NEW PATIENT REGISTRATION & CONSENT FORM**	
Phone: 03 9084 7400	**Mail:** PO Box 2226, Mount Waverley 3149	**Website:**
Fax: 03 8610 0028	**Email:** reception@infinityhealth.au	www.infinityhealth.au

We need this information to provide the best quality care. This form complies with the RACGP Standards for general practices. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.

Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records and allow us to contact you promptly about tests and results.

Section A: Personal Details

Title:	Surname:	Given names:
Preferred name:		Date of birth: / /
Gender: ☐ Male ☐ Female ☐ Other:		Gender assigned at birth: ☐ Male ☐ Female ☐ Other:
Preferred Pronouns: ☐ He/Him/His. ☐ She/Her/Hers. ☐ They/Them/Theirs. ☐ Other:		
Marital Status: ☐ Single. ☐ Married. ☐ De facto. ☐ Separated ☐ Divorced. ☐ Widowed		
Medicare Card Number:	Medicare Reference Number:	Expiry date:
Pension, Health Care Card or Veterans Affairs Number (if applicable):		
Occupation prior to retirement:		
Name of Residential Aged Care Facility:		
Telephone/Mobile Number:	Email:	

NEXT OF KIN

Name:	Relationship to patient:
Home Phone Number:	Mobile Phone Number:
Email:	

EMERGENCY CONTACT DETAILS (If different to Next of Kin): Who can we contact in an emergency?

Name:	Relationship to patient:
Home Phone Number:	Mobile Phone Number:
Email:	

ADMINISTRATION

Medical Power of attorney & contact details:
Legal power of attorney if different from above:
Do you have an advance health directive for end of life care? ☐ Yes. ☐ No.

Section B: Cultural Background

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander origin?

☐ No ☐Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐Yes – Aboriginal and Torres Strait Islander

Ethnicity: ☐ Australian ☐ Other cultural background (eg. Mediterranean, Asian, African):

Country of birth:

Is English your first language: ☐ Yes ☐ No	If not, what is your first language:

Do you require an interpreter: ☐ Yes (Language:) ☐ No

Section D: Social and health history

Smoking: ☐ Non-smoker. ☐ Ex-smoker. ☐ Smoker. Date started: /day

Alcohol: ☐ Non-drinker. ☐ Ex-drinker. ☐ Drinker. /day. How many days per week:

Section E: Consent

MEDICAL SERVICES REQUEST

Infinity Health has been requested to provide patient medical services by either the patient or his/her next of kin or his/her medical power of attorney.

CONSENT TO BULK BILL

Infinity Health and associated health care providers have my consent to provide bulk billed services as per item numbers displayed in the Royal Australasian College of General Practitioners (RACGP) aged care clinical guide (Silver Book) Medicare Benefits Schedule item numbers, 5th edition and I understand and agree with any updates that may follow to the Medicare Benefits Schedule relevant to my care. See attached document from the RACGP Silver Book. Also available at https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/silver-book-part-b/medicare-benefits-schedule-item-numbers

PRIVATE FEE PAYMENTS

We charge a small, out of pocket fee for services not covered by Medicare, such as paperwork and forms for taxi cards, disabled parking, capacity/proof of life letters, Centrelink forms, proof of identity for banking services, carer's leave medical certificates etc. To make a request, please contact our administrative team via email and they will get in touch with you to explain the fee involved and help you arrange payments via bank transfer to ensure your request is progressed without delay.

MEDICAL CONSENT & AUTHORITY TO RELEASE MEDICAL RECORDS

This general practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the Privacy Act 1988 and Australian Privacy Principles, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as an Authorised Medical Treatment Decision Maker) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

At all times we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

By signing below, you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

CONSENT FOR RECEIVING RECOMMENDED VACCINATIONS

By signing this consent form, I acknowledge that I have been informed about the importance of immunisations and the vaccines recommended in the Australian Immunisation Handbook. I understand that these vaccines, including but not limited to influenza, COVID-19, pneumococcal, and shingles, play a key role in protecting my health by preventing serious diseases and their potential complications. I acknowledge that immunisations are an essential part of preventive healthcare and contribute to my well-being and the health of the community.

I consent to receiving any immunisations that are recommended for me, as outlined by my healthcare provider in accordance with the Australian Immunisation Handbook and relevant public health guidelines. I understand that the decision to recommend a specific vaccine may depend on factors such as my age, health status, and individual risk factors, and my healthcare provider will discuss these factors with me before administering any vaccine. I am aware that these vaccines are designed to protect against preventable diseases that can have serious, long-term health effects.

I understand that receiving immunisations may involve certain minor side effects, such as swelling, redness, or mild fever at the injection site. While serious side effects are rare, I have been made aware of the potential risks and benefits associated with each vaccine. I am encouraged to ask any questions or raise concerns I may have about vaccines with my healthcare provider before proceeding with immunisation.

By consenting to immunisations, I acknowledge that I understand the importance of staying up to date with recommended vaccines and that I have the right to withdraw my consent for any vaccine at any time. If I have any concerns or require further information about any vaccine, I will discuss them with my healthcare provider.

If there are any vaccinations that you **do not** wish to receive, please list these below:

TELEHEALTH INFORMED CONSENT

By signing this consent form, I acknowledge that I have been informed about the option to participate in telehealth consultations as part of my care with this general practice. Telehealth consultations allow me to connect with my healthcare provider remotely, using video, phone, or other secure communication methods, to discuss my health concerns, receive medical advice, and manage my ongoing treatment, especially when in-person visits are not feasible or convenient.

I understand that telehealth consultations are an effective and secure way to receive medical care, but they may have some limitations compared to in-person consultations. These limitations may include potential issues with technology, difficulties in conducting physical examinations, and challenges in communication. I am aware that my healthcare provider will assess whether a telehealth consultation is appropriate for my condition, and I have the right to request an in-person consultation if I feel it is necessary for my care.

I consent to the use of telehealth for consultations, acknowledging that my healthcare provider will take all reasonable steps to ensure the confidentiality and privacy of my personal health information during these consultations. I understand that the telehealth platform used will comply with relevant privacy and data protection laws to protect my medical information.
I also understand that telehealth consultations may not always be suitable for all health issues and that, in certain circumstances, an in-person visit may be required. Should a telehealth consultation not be appropriate for my needs, I will be advised accordingly and an alternative solution, such as an in-person visit or referral, will be discussed.

I consent to receiving healthcare via telehealth as part of my registration with this practice, and I understand that I have the option to withdraw my consent at any time.

CONSENT TO USE OF ARTIFICIAL INTELEGENCE TECHNOLOGY

An important aspect of how we document our consultations is that we utilize a note taking tool called Heidi to accurately and efficiently capture the details of our discussions and the outcomes of our appointments. Heidi ensures that we can focus more on our conversation and less on manual note taking, enhancing the quality of care you receive.

Your consent is crucial for us to use this technology. Please understand that your information will be handled with the utmost care, and Heidi's use is aimed solely at improving your healthcare experience.

Heidi is used to assist with documenting your consultation, capturing only what is necessary for accurate medical records. Heidi supports but does not replace your clinician's professional judgment. All medical decisions are made solely by your clinician.

Your data is processed and stored in your jurisdiction and in accordance with applicable privacy laws.
None of your data is used for secondary purposes. Data is undergoes a rigorous de-identification process to remove personal identifiers. Data is handled securely, with encryption and regular audits to ensure compliance.

You can choose to opt-out of the use of Heidi during your consultation.

By signing this consent form, you acknowledge that:
1. You have been informed about the use of Heidi and its purpose.
2. You understand how your information will be handled, stored, and protected.
3. You agree to allow your clinician to use Heidi to assist with documenting your consultation.
4. You understand that you can withdraw your consent at any time without affecting the quality of care you receive.

UPLOADING HEALTH INFORMATION TO MY HEALTH RECORD INFORMED CONSENT

By signing this consent form, I acknowledge that I have been informed of the opportunity to have my health information uploaded into My Health Record, a secure and accessible digital health platform. My Health Record allows for the safe storage and sharing of my health information between authorized healthcare providers. This service is designed to help ensure that my medical history is available when needed, whether in routine care or in emergencies.

I understand that the health information to be uploaded may include details such as my medical history, medications, allergies, test results, and other relevant health information. I also understand that this information will be accessible to authorized healthcare professionals involved in my care, ensuring that my treatment is informed and coordinated. Additionally, I am aware that I have the right to request access to my record, and I can make changes or remove information, subject to applicable laws and regulations.

By consenting to the upload, I acknowledge that I have been informed of my rights and the benefits of My Health Record, and that I can choose to withdraw consent at any time. I understand that, should I choose to withdraw my consent, my information will no longer be accessible to other healthcare providers through the My Health Record system. However, any information that has already been shared may remain in the system.

I consent to the upload of my health information to My Health Record as part of my registration with this practice, and I confirm that I understand the implications of this decision.

_____ *Patient / Medical power of attorney signature* Your Name (if patient unable to sign): _____ Relationship to patient (if signing on their behalf): _____ _____	_____ *Date*

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e: **reeption@infinityhealth.au**
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AUTHORITY TO RELEASE MEDICAL RECORDS

To facilitate continuity of care, Infinity Health requests a copy of all new patients' previous medical history. Please confirm the following details so we can obtain the previous history:

GP/SPECIALIST NAME: _____

CLINIC NAME: _____

PHONE/FAX NUMBER: _____

EMAIL: _____

Re: (Name of Patient) _____

DOB:_____

Name of Residential Aged Care Facility:_____

Next of Kin/medical POA Name: _____

Contact number(s) of Patient or NOK/mPOA:_____

Please provide permission for the above named patient's practitioner to forward a Patient Health Summary Report that includes the following:

- **Medical History**
- **Allergies**
- **Current medications**
- **Recent Pathology results**
- **Immunisation history**
- **Advance Care Plan Directive**
- **Other relevant notes/reports**

Signature: _____

Your Name (if patient unable to sign): _____

Relationship to patient (if signing on their behalf): _____

Date: _____

Australian Government

my medicare

MyMedicare Registration Form

MyMedicare is a voluntary patient registration model. MyMedicare aims to formalise the relationship between patients, their general practice, general practitioner (GP) and primary care teams. MyMedicare patients and their usual GP and practice will have access to new benefits to help deliver more of the care patients need, improving health outcomes.

Your completed MyMedicare Registration Form should be provided to your preferred general practice to complete your registration process.

Patient details

Family name

First given name

Second given name

Date of birth

(dd) (mm) (yyyy)

Medicare number or DVA file number

Medicare IRN

Practice and provider details

Practice name

Infinity Health

Practice address

PO BOX 2226 Mt Waverley 3149

Name of preferred GP

Dr Siaw Wei Hong

By signing this form I agree to the following:
I understand that registering in MyMedicare is voluntary.

1. I consider this practice to be my regular primary health care provider.
2. I understand that I can only be registered with one practice at a time. By submitting this form, any existing registration in MyMedicare will be withdrawn, and my previous practice and provider will automatically be notified that I am no longer registered with them under MyMedicare.
3. I understand that I will remain registered unless:
   - I register with a different practice.
   - I request my GP/practice or Services Australia to withdraw my registration.
   - My GP or practice decides to withdraw my registration.
4. I understand that there is no cost to register in MyMedicare.
5. I declare I have read and understand the MyMedicare Privacy Notice and consent to my personal information being collected, used and disclosed by the relevant agencies such as Services Australia, the Department of Health and Aged Care, the Australian Digital Health Agency and, where applicable, the Department of Veterans' Affairs as specified in the MyMedicare Privacy Notice (a link to this notice is provided in the Privacy Statement at the bottom of this form).
6. I understand that I can register for MyMedicare even if the information requested in the 'About You' section of this form is not provided.

Full name of individual providing consent (patient, patient's guardian/attorney or parent if required)

Signature

Date

If a parent or guardian has completed this form on behalf of a patient aged 14-17, please confirm the patient is aware of this registration and provided informed consent. ☐ Yes

Consent for MyMedicare registration for patients under 14 years of age must be provided by the patient's parent or legal guardian.

Patients aged 14-17 years must provide their consent to register for MyMedicare.

- A parent or guardian of a patient aged 14-17 years may complete the registration form if the 14-17 year old is aware of the registration and has provided their consent for this person to act on their behalf.

For a patient 14 years or older, who lacks capacity to make decisions for themselves, consent for the MyMedicare registration will need to be provided by an individual who is authorised to act on the patient's behalf.

About you

The information you provide will help your practice and the government to plan and improve your health care services. We will share this information with your MyMedicare practice. If you choose not to provide this information as part of your registration, you will still be able to register for MyMedicare. You may still provide this additional information about you directly to your practice.
We may already have your information if you have registered in the past.

1. Are you of Aboriginal or Torres Strait Islander descent?

- ☐ No
- ☐ Yes - Aboriginal Australian
- ☐ Yes - Torres Strait Islander Australian
- ☐ Both Aboriginal and Torres Strait Islander Australian
- ☐ Prefer not to answer

2. In which country were you born?

- ☐ Australia
- ☐ England
- ☐ New Zealand
- ☐ India
- ☐ Philippines
- ☐ Vietnam
- ☐ Italy
- ☐ South Africa
- ☐ Malaysia
- ☐ Scotland
- ☐ Other (please specify) ☐
- ☐ Prefer not to answer

3. What is the main language you speak at home?

- ☐ English only
- ☐ Mandarin
- ☐ Arabic
- ☐ Cantonese
- ☐ Vietnamese
- ☐ Italian
- ☐ Greek
- ☐ Hindi
- ☐ Spanish
- ☐ Punjabi
- ☐ Other (please specify) ☐
- ☐ Prefer not to answer

4. How well do you speak English?

- ☐ Very well
- ☐ Well
- ☐ Not well
- ☐ Not at all
- ☐ Prefer not to answer

5. How do you describe your gender?

Gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents. Please select one box:

- ☐ Man or male
- ☐ Woman or female
- ☐ Non-binary
- ☐ I use a different term
- ☐ Prefer not to answer

6. How do you describe your sexual orientation? Only complete this question if you are aged 15 years or over.

Please select one box:

- ☐ Straight (heterosexual)
- ☐ Gay or lesbian
- ☐ Bisexual
- ☐ I use a different term
- ☐ Don't know
- ☐ Prefer not to answer

7. In everyday life, do you have difficulty participating in any of the following, related to a long-term health condition or disability?

A. Daily activities such as:
- washing, dressing
- walking, handling or lifting objects
- speaking, using communication devices

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

B. Activities of independent living, such as:
- shopping, cooking, caring for others
- making decisions, handling stress
- learning, solving problems
- relationships with people

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

C. Activities of work, education and community living, such as:
- social and community life
- work, education or training

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

8. The categories below are disability groups based on underlying health conditions and or impairments, activity limitations and participation restrictions. Which of the following best describes your health condition or disability? (Please tick the box next to any that apply – you can select more than one box)

- ☐ Sensory (e.g., sight, hearing, speech)
- ☐ Intellectual (e.g., difficulty learning or understanding)
- ☐ Physical (e.g., breathing difficulties, chronic or recurrent pain, blackouts or seizures, incomplete use of limbs)
- ☐ Psychosocial (e.g., nervous or emotional conditions, social or behavioural difficulties)
- ☐ Head injury, stroke or acquired brain injury
- ☐ Other
- ☐ Prefer not to answer

Office use only

Provider Number of preferred GP _____

Please select a box to confirm the patient's eligibility

- ☐ The patient has received 2 or more face-to-face MBS services with the practice in the previous 24 months
- ☐ The patient meets the reduced eligibility criteria of one or more face-to-face MBS services with the practice in the previous 24 months and the practice is located in MMM6-7

The patient meets one of the exemption criteria:

- ☐ Children under 18 years whose parent is already registered at this practice
- ☐ Parents of a child under 18 years who is already registered at this practice
- ☐ Patient is following a GP they are registered with to this practice
- ☐ Patient experiencing family and domestic violence
- ☐ Patient experiencing homelessness

The practice will retain a copy of this registration form in the patient's clinical records, for compliance of record keeping obligations in accordance with federal, state and territory legislation applicable to their practice.

Privacy Statement

The law regulates how Services Australia, the Department of Health and Aged Care, the Australian Digital Health Agency and the Department of Veterans' Affairs may handle your personal information. Services Australia is collecting your personal information to assess your eligibility for MyMedicare and provide services to you and payments linked to your provider as a result of your MyMedicare registration. Your information will only be shared with relevant government agencies such as the Department of Health and Aged Care, Australian Digital Health Agency and the Department of Veterans' Affairs, where you have agreed, or where the law allows or requires it. The MyMedicare Privacy Notice describes how your information will be managed consistent with our obligations under the Privacy Act 1988 and the Australian Privacy Principles. The notice can be found at https://www.health.gov.au/resources/publications/mymedicare-privacy-notice.

You can also read the:

- Services Australia privacy policy at: www.servicesaustralia.gov.au/privacy
- Department of Health and Aged Care privacy policy at: https://www.health.gov.au/resources/publications/privacy-policy
- Australian Digital Health Agency privacy policy at: https://www.myhealthrecord.gov.au/about/privacy-policy, and
- Department of Veterans' Affairs privacy policy at: https://www.dva.gov.au/privacy-policy.