HARBOUR VASCULAR
Dr Mayo Theivendran FRACS
LABORATORY

NEW PATIENT DETAILS FORM

PERSONAL INFORMATION

Title : ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mstr ☐ Other **DOB** : / /

Full Name :

Address :

Home Phone : **Mobile** :

E-Mail :

Occupation :

Medicare # : **Ref #** : **Expiry** :

Private Health Fund : **Membership #** :

Pension # : **Expiry** :

DVA Card : ☐ Gold ☐ White **DVA #** :

ARE YOU COVERED UNDER WORKERS COMPENSATION? ☐ Yes ☐ No *If no, please skip to emergency contacts details*

Claim # : **Injury date** : **Case Manager Name** :

Case Manager Phone : **Case Manager Email** :

Insurer :

EMERGENCY CONTACT DETAILS

NOK Name : **Relationship** :

Mobile : **Email** :

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD:

High blood pressure : **Diabetes** :

High cholesterol : **Heart disease** :

Stroke / TIA : **Lung disease** :

HARBOUR VASCULAR
Dr Mayo Theivendran FRACS
LABORATORY

NEW PATIENT DETAILS FORM

Do you smoke : _____ **How many / often** : _____

Did you smoke : _____ **When did you cease** : _____

Do you drink alcohol : _____ **How much / often** : _____

Allergies : _____

MEDICAL HISTORY

Previous operations : _____

_____

_____

GP name : _____ **Phone** : _____

Practice name : _____

Names of specialists you see on a regular basis + location : _____

_____

_____

INFORMATION ABOUT FEES

A valid referral from your GP or Specialist is required PRIOR to seeing Dr Theivendran. Your GP referral last for 12 months and a specialist referral last for 3 months.

- **Initial consultation $330. Medicare rebate $81.30**
- **Follow up consultation $180. Medicare rebate $40.85**
- **Pension card holder - initial consultation $210 and follow up $150**

All ultrasounds at Harbour Vascular Laboratory are **BULK-BILLED** if you hold a current Medicare card. If you hold overseas health insurance you will be required to settle the ultrasound account in full and claim from your fund as we are unable to directly bill the insurers.

Dr Theivendran may occasionally be delayed by a complex patient, we apologise in advance and thank you for your understanding.

By signing this form you agree that the information provided is correct to the best of your knowledge and you have read the information regarding the doctors fees.

_____ _____

SIGNATURE **DATE**

HARBOUR VASCULAR
Dr Mayo Theivendran FRACS
LABORATORY

NEW PATIENT DETAILS FORM

PRIVACY POLICY

Collection of personal information, Privacy Act 1988 (Cwlth) and HRIP Act 2002 (NSW) Amended March 2014.

Harbour Vascular & Harbour Vascular Laboratory 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 the doctor may properly assess, diagnose and treat illnesses and be proactive in your health care. We will also use the information you provide in the following ways:

- Administrative purposes in order to run our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside of this practice.
- Disclosure to other doctors in this practice, locums and registrars attached to the practice for the purpose of teaching. Please let us know if you do not want your records accessed for this purpose and we will note your file accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to opt out of any such involvement.
- Your information will also be held for billing purposes by Northern Beaches Vascular who we utilise for vascular scanning whilst at Northern Beaches Hospital.

I have read the above information and understand the reasons why my information is collected. I understand that I am not obliged to provide any information requested of me but that my failure to do so might compromise the quality of health care and treatment given to me.

I am aware of my right to access the information collected about me, except in the circumstances where access may be legitimately withheld. I understand I will be given an explanation in these circumstances. I understand that if I request access to information about me, the practice will be entitled to charge fees to cover time and administrative costs which may not be covered by a Medicare rebate.

I understand that my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on accessor disclosure that I notify this practice of.

SIGNATURE **DATE**