Era Health
Work Solutions

OCCUPATIONAL HEALTH
WORKCOVER CONSENT FORM

PATIENTS DETAILS

Title _____ First Name _____ Surname _____

CONSENT

I consent to medical intervention by Era Health practitioners and authorize Era Health practitioners and administrative staff who provide a medical service to me in connection with this injury, to disclose relevant information to my employer and persons directly involved in the management of my injury, and to any person or organization authorized by me or by law to obtain this information.

I, _____ have read and understood the above condition of being a patient at this practice, and I acknowledge that the information given on this form is true and accurate to the best of my knowledge.

Signature **Date**

FOR ERA HEALTH USE ONLY

ENTERED BY: **CHECKED BY:** **DATE:**

PRIVATE PATIENT REGISTRATION FORM

PATIENTS DETAILS

Title _____ First Name _____ Surname _____

D.O.B _____ Address _____ Suburb _____ Post code _____

Phone No: (H)_____ (W) _____ (M) _____

Email _____ Employer _____

Referrer's Name _____ Phone _____

Next of Kin or Parent/Guardian _____ Phone _____

Emergency Contact _____ Phone _____

TAC / Work Cover (circle) Claim No _____

Medicare No _____ Ref No _____ Expiry _____

Private Health Insurance YES NO If yes, name of fund _____ Membership No_____

Are you of Aboriginal or Torres Strait Island descent? NO/YES if yes _____

Pension, Health Care or Veterans Affair card No.(if applicable) _____ exp:_____

How did you hear about us? (please tick the box)

☐ **Word of Mouth** ☐ **Yellow Pages** ☐ **Google Search** ☐ **Health Fund**

☐ **Brochures** ☐ **Signage** ☐ **Employer** **Other** _____

CONSENT

I consent to the use of my personal health information by the Era Health and other health providers involved in my medical treatment and health care.

I consent to the disclosure of my personal health information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment.

Our Practice uses a reminder system to improve the quality of your health care and to promote preventative health care. Our practice routinely sends out health related newsletters, reminder emails and we telephone and send SMS reminders for appointments and procedures including vaccinations, PAP tests and other health reviews. You may opt out of receiving any or all of these communications at any time.

CANCELLATION POLICY

We require at least 12 hours notice to cancel or change your appointment. Failure to give this notice may result in a cancellation fee of $70 being charged.

PAYMENT OF THE CANCELLATION FEE IS REQUIRED WITHIN 7 DAYS

I, _____ have read and understood the above condition of being a patient at this practice, and agree to pay the cancellation fee should I cancel without giving 12 hours notice. I acknowledge that the information given on this form is true and accurate to the best of my knowledge.

_____ _____

Signature **Date**

FOR ERA HEALTH USE ONLY

ENTERED BY: **CHECKED BY:** **DATE:**