Northern Beaches
IMMUNOLOGY & ALLERGY

Dr. James Yun MBBS, FRACP, FRCPA, PhD(Bern)
Consultant Physician (Immunology and Allergy) Provider No. 253329HJ

NEW PATIENT INFORMATION FORM

Mr / Mrs / Ms / Miss / Other _____
Title (circle one) **First Name** **Middle Name** **Surname**

Address: _____ **Suburb** _____

State _____ **Postcode** _____ **Mobile** _____ **Home Phone** _____

Emergency / Secondary Contact No. _____**: Relationship to Patient (please indicate)** _____

Date of birth _____/_____/_____ **Email** _____

Medicare No. _____ _____ **Reference on card** _____ **Expiry Date** ____/_____

How did you hear about us? _____ **Preferred method of communication (circle one)** Email/Phone or Either

Private Health Care Name & No. / Pensioner Card No. & Exp.Date / DVA Card No. & Colour _____

Referring Doctor _____ **Specialist / GP Referral (circle one)**

Usual GP (if different from above) _____ **Usual GP Phone No.** _____

Are there other medical practitioners you would like correspondence to be sent to apart from your referring doctor and usual GP? If so, please list them:

_____
Name Address Phone

CONSENT TO COLLECT PATIENT INFORMATION

This medical 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 medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes including compliance with Medicare for assignment of benefit to doctor and claiming patient's rebate.
3. Health Insurance Commission requirements.
4. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

- I understand the reasons why my information must be 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 the health care and treatment given to me.
- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
- I understand that if my information is to be used for any purpose other than the above, my consent will be sought.
- I consent to the handling of my information by this practice access or disclosure for the purposes set out above, subject to any limitations on of which I may notify this practice.
- I consent for the assignment of Medicare benefit to doctor for all telehealth consultations unless I am privately billed with gap.

_____/_____/_____
Guardian//Parent/Patient's Name (please print) Signature Date

Suite 75, 23 Narabang Way Belrose NSW 2085 ph 02 9450 0687 fax 02 8209 4882
www.nbia.com.au info@nbia.com.au

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SERVICE PAYMENT AND MEDICARE CLAIMANT DECLARATION

I will pay for or am liable to pay the expenses for doctor's services and these services are not excluded under the Health Insurance Act 1973 (i.e. are not for the purpose of life insurance, superannuation or provident account schemes, admission to a friendly society, health screening, mass immunisation or connected with employment) and/or Dental Benefits Act 2008.

To the best of my knowledge and belief all the information provided to Northern Beaches Immunology & Allergy for the lodgement of Medicare claim is true and accurate. I authorise the medical practice to electronically transmit my claim for Medicare benefits to the Australian Government Department of Human Services on my behalf.

I also authorise the Australian Government Department of Human Services to contact the referring provider or the provider of the services if clarification of details on the account and/or receipt is required for assessment or auditing purposes.
For my Medicare claim, I consent to this practice sending to, and receiving from the Australian Government Department of Human Services, the following information for verification:

- The patient's enrolment information including the patient's Medicare card and issue number;
- The patient's first name and individual reference number;
- The claimant's postcode information provided it matches my records; and
- The benefit amount for each service in this claim.

Privacy Notice: Your personal information is protected by law, including the Privacy Act 1988, and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim.

The Medicare Benefit will be paid:

If your bank account details are stored with Medicare your payment will be made by EFT, if not, your Medicare benefit will not be paid. Once you have provided Medicare with your bank account details, your payment will be released.

If required, correspondence regarding the claim will be directed to the:
ADDRESS HELD BY MEDICARE

This includes, if applicable, any Pay Doctor via Claimant (PDVC) cheques for the service provider. It is the responsibility of the claimant to forward the PDVC cheque to the service provider or to bring it to Medicare office for further enquiry.

I have read, understood and accepted all of the above information.
I will notify the practice at the time of payment if I choose to subimt my own Medicare claim.

_____/_____/_____
Guardian//Parent/Patient's Name (please print) Signature Date

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