

Vision Care Partners Ltd - Patient Enrolment Form

Title: Dr/Mr/Mrs/Ms/Miss/Mx <i>(Circle one)</i> Surname: Date of Birth:	First Names: Known as: Name of guardian if under 16 years:
Postal Address: Email: <i>(Email is the preferred method of correspondence, please only provide if you are happy to receive information from us via email)</i>	Mobile Phone: Home: Work:
GP/Medical Centre: Optometrist:	Insurance ☐ NO ☐ YES If yes please provide details: Insurance Company: Membership Number: <i>Please note we are Southern Cross Affiliated – we can apply for pre-approval and claim on your behalf</i>
Only if ACTIVATED – POWER OF ATTORNEY NAME: ADDRESS: PHONE:	Is this treatment to be claimed under ACC? Yes ☐ No ☐ If so, what is your ACC claim number?

Please tell us if you have any special needs (e.g. hearing or visual impairment or language difficulties) you wish your consultant to be aware of before treatment:

Vision Care Partners Ltd Privacy Statement:

By accepting health care services from us, you agree we can collect information about you from other agencies for the purpose of maintaining an up-to-date health record and providing safe and quality ophthalmic health care. This may include:

- Give/obtain specific medical information regarding my injury/condition to/from other health professionals concerned with my care – including receipt of correspondence such as discharge summaries, outpatients or specialist letters.
- Access authorized national or regional health information systems to support your care by checking relevant medical history, laboratory or radiology results and current prescribing.
- Proactively contacting a hospital or specialist service to follow up on a referral or seek advice or an update on your care, where that contact results in information about you being shared with us.

I understand that data regarding my condition and outcomes may be used anonymously for subsequent audit purposes and understand that any results disseminated from such audit will be anonymized and not contain any individual identifying information.

I understand that I have the right to request access to the health information Vision Care Partners holds about me, and request correction of that information if I believe it to be inaccurate.

I understand that if concerns are raised about the care or services provided by Vision Care Partners Ltd that we may disclose relevant health information to our regulators, insurers, indemnity providers or legal advisers for the purpose of managing and responding to the concerns.

I HEREBY CONSENT for the Ophthalmologist to

- Carry out appropriate assessment and tests, with an explanation of techniques and their possible consequences. I am aware that I should ask for further explanation if I am unclear about any aspect of my assessment or treatment.
- Share my clinical data with other health professionals concerned with my care such as my GP, Optometrist, and/or other Specialist.
- I am aware that I am able to bring a support person/whanau with me and have them present for part or all my treatment.
- I accept responsibility to meet the cost of treatment. (In some cases, ACC/Insurance companies may decline cover, and additional charges may apply) and that a fee may apply for failing to attend appointments.

Signed: _____

Date: _____

TERMS OF TRADE

Our terms are strictly cash / eftpos / direct credit

If accounts are not paid by the due date, associated costs may be charged for the recovery of your debt.

Logan. Casey. Harry