Please complete this three page form and fax to 9421 5148 or bring to your appointment or email if instructed to by practice staff

CONFIDENTIAL PATIENT REGISTRATION, BREAST HEALTH and FEE POLICY FORMS

EPWORTH BREAST SERVICE
Suite 7.8, Level 7, 32 Erin Street, Richmond 3121
Tel: 9421 4218 Fax: 9421 5148

TITLE: Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Mr ☐ Other (Specify) ☐

GIVEN NAMES:

PREFERRED NAME:

SURNAME:

HOME ADDRESS:

DOB

CONTACT DETAILS

TELEPHONE: Home

Work

Mobile

(used for important SMS appointment confirmation/reminders)

EMAIL:

POSTAL ADDRESS: (if different from home address)

MEDICARE NO:

EXPIRY DATE:

PRIVATE HEALTH INSURANCE: YES ◯ NO ◯

HEALTH FUND:

MEMBERSHIP NO:

VETERANS AFFAIRS:

Pension/HCC No:

EMERGENCY CONTACT:

SURNAME:

GIVEN NAMES:

RELATIONSHIP:

TELEPHONE CONTACT DETAILS

Home

Mobile

GENERAL PRACTITIONER:

REFERRING DOCTOR (IF NOT GP)

We may need to contact you after your appointment.
If you are unavailable may we leave a message ?

Home Answering Machine

◯ Yes ◯ No ◯ N/A

Mobile phone voicemail

◯ Yes ◯ No ◯ N/A

With a family member at home

◯ Yes ◯ No ◯ N/A

May we contact you at work?

◯ Yes ◯ No ◯ N/A

May we SMS/text you?

◯ Yes ◯ No ◯ N/A

May we email you?

◯ Yes ◯ No ◯ N/A

OCCUPATION:

Epworth Breast Service Breast Health History

Name: _____ DOB: _____ Age: _____

Menopausal Status: Pre ☐ Peri ☐ Post ☐ Unknown ☐

When was your last period? Date___ Month____ Year_____ Have you had breast cancer in the past? Yes ☐ No ☐

Are you pregnant or breastfeeding? Yes ☐ No ☐ Do you have breast implants? Yes ☐ No ☐

Have you had any breast surgery in the past? Yes ☐ No ☐ If yes, which breast? R ☐ L ☐ Both ☐

Previous Mammogram: Yes ☐ No ☐ If yes, approximate date: Date ___ Month____ Year _____

Location: _____

Smoking: Never ☐ Given Up ☐ Occasionally ☐ Current ☐

Are you taking: HRT: Yes ☐ No ☐ Year Started_____ Oral Contraceptive Pill : Yes ☐ No ☐

Have you had a hysterectomy? Yes ☐ No ☐ If yes, were your ovaries removed? Yes ☐ No ☐ Don't Know ☐

Do you have a family history of breast or ovarian cancer? Yes ☐ No ☐ Unknown ☐

If yes, please list details:

Relative	Age at Diagnosis	Breast or Ovarian
_____	_____	_____
_____	_____	_____

Are you of Jewish ancestry? (this may be relevant with respect to your genetic risk) Yes ☐ No ☐

Medications- please list:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Drug Allergies: Nil Known ☐ Yes ☐ (Please list) _____ _____ _____

Significant Medical History:

Diabetes ☐ Heart Disease ☐ Blood Thinners ☐ High Blood Pressure ☐

Other _____

Signed _____ Name: _____

Date: _____

Please Note: One of our Breast Care Nurses is routinely present during most consultations. Please advise us prior to going in to your consultation if you would prefer a breast care nurse not to be present.

Epworth Breast Service Policies

- This practice is committed to ensuring high-level privacy for all personal health information including photographic records, collected, used and disclosed in the course of effective patient care. During this process, both collection and sharing of health information with other medical and allied health professionals may be necessary. This may include, for patients with a breast cancer diagnosis, entry of de-identified data into the BreastSurgANZ Quality Audit previously the National Breast Cancer Audit) Database, sharing of your contact details with BCNA (Breast Care Network Australia) to order your "My Journey Kit ,"a specially designed package of information for Australians diagnosed with breast cancer.) and case discussion at our weekly Epworth Breast Multidisciplinary Team Meeting.
- I consent that photographs be taken of me if required. I understand that these photographs form an essential part of my medical record, as well as my preoperative and postoperative assessment. I understand and consent to my photographs being used for medical research, teaching and or patient education purposes. I understand that I will not be identified by name in any such use of these photographs, nor will my identity be recognisable.
- Should my health information be required for purposes other than those listed above, I understand that my further consent will be required. A copy of the 'Epworth Breast Service Privacy Policy' is available upon request.

Fee Policy

The Medicare Rebate for an outpatient service is 85% of the Schedule Fee. The "gap" between the amount charged and this 85% rebate is not covered by your private health insurance for outpatient services and therefore a financial obligation on yourself arises and you will face an "out -of-pocket" charge. The Australian Medical Association (AMA) recognises that Medicare benefits levels are fixed arbitrarily by the federal government and that benefit levels have not kept pace with inflation, the costs of running a practice and medical indemnity, thereby widening the gap between reasonable fees and Medicare benefits. The fees charged by the Epworth Breast Service have been determined after careful study and investigation of practice costs and other relevant and material circumstances, and are considered as being fair, reasonable and appropriate for the services provided.

		Charge	Medicare Rebate (ie 85% of schedule fee)
Initial Consultation			
	Standard	$245	$72.75
	Second Opinion	$335	
Review Consultation			
	Standard Review	$120	$36.55
	Long-term follow up	$145	

Payment is appreciated on the day of consultation.

- If your consultation is prolonged, an additional charge at a pro-rata rate will be incurred.
- An additional charge will be made for any diagnostic services or procedures (eg ultrasound scan, needle biopsy, cyst aspiration) performed during your consultation. A full price list is available upon request.
- X-rays and pathology tests, if required, will be performed by other independent practices and you will be charged separately for those services
- Epworth Breast Service has a policy of informed financial consent and should you subsequently be booked for an operation you will be provided with a written quote prior to any procedure if there is to be an out-of-pocket expense. Proceeding with surgery after having received a written estimate of the surgical fee will be taken to be informed financial consent.
- If you are re-referred by your GP following discharge from this practice, a "new/initial" consultation will be charged.
- Cancellations on the day of appointment may incur a $50 cancellation fee.

I have read and agree to the above policies.

Signed: _____ Name: _____

Date: _____

Referral Source: How did you hear about us?

☐ Referred by doctor ☐ BreastScreen ☐ Website ☐ Facebook

☐ Personal recommendation:_____ ☐ Other:_____