

Your details

Privacy notice: FPV is compliant with all requirements of the Health Records Act, Victorian & Commonwealth Privacy Legislation and the Australian Privacy Principles. We will only collect relevant information from clients for the purpose of providing a service. A copy of our Privacy Policy is available from reception or via our website at www.fpv.org.au

Surname:	Title: Miss/Ms/Mrs/Mr/Dr	Date of birth: / /
First name:	Other name/s:	Male / Female / Trans / Other

Contact information

Postal address: _____ Postcode: _____

Residential address as above **OR:** _____

Telephone (Mobile preferred) _____ Email: _____

To ensure your privacy, we ask you to create a password. This will be requested before we give any results.

Your password: _____

Cultural identity

<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal & TSI <input type="checkbox"/> None of the above	Country of birth: _____ Language spoken at home: _____ Preferred language: _____ Are you an overseas visitor? Yes / No (please circle) <input type="checkbox"/> Interpreter required: _____ (language)
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Follow up and results

I understand I may be contacted by FPV if my results require follow-up, as per FPV follow up policies and/or protocols:

- At any of the above contact numbers or addresses
- Only via the numbers/addresses below
 - Home address Home phone Work phone
 - Mailing address Mobile/Ph/SMS Email

For cervical screening (Pap test) clients:

- Yes** I authorise FPV to access my personal and health information at the Victorian Cervical Cytology Registry, for the purposes of Pap test follow up.
- No**

Medicare details

IF YOU DO NOT HAVE AN AUSTRALIAN MEDICARE ACCOUNT, YOU WILL BE ADVISED OF ANY APPROPRIATE CHARGES DUE TODAY, PAYABLE AT THE END OF YOUR CONSULTATION.

Medicare Card number: _____

Ref No. (next to your name on the card: _____

Expiry Date: ____ / ____ / ____ (If you do not have your Medicare card we can obtain this from Medicare for you.)

Do you have any of the following health concession cards?

- Health Care Card Number: _____ Expiry: ____ / ____ / _____
- Pensioner Concession Card Number: _____ Expiry: ____ / ____ / _____
- Other: _____ Number: _____ Expiry: ____ / ____ / _____

How did you hear about our clinic?

- Web search
- FPV website
- Friend or family
- FPV education session
- GP or health professional / nurse
- Other: _____

Clinic administration fee (annual fee) information

Our consultations are free or low cost and we charge a small annual fee. This gives you unlimited access to our clinics and services for one year. Payments can be made at reception via Cash, Cheque, Eftpos or Credit Card.

The current fee schedule for the annual fee is:

Full fee / Standard: \$36.00

Concession rate: \$10.50

Declaration

I undertake to inform FPV if there is a change in my circumstances such as, for example, change of address, contact number, Medicare status.

Signature: _____ Date: ____ / ____ / _____

OFFICE USE ONLY

FPV MRN: _____

Paper or archived file Yes No