MR JAMES CHIU
MBBS FRACS (orth.)
ORTHOPAEDIC SURGEON

看診者登記表 (WORKCOVER 職場傷害/TAC 交通傷害)

Personal Details 個人資料

Title 頭銜: Mr Mrs Ms Miss Dr Prof (Please Circle 請圈選)	
First Name 名字:	Middle Name 中間名字:
Preferred Name 希望被稱呼的名字:	
Surname 姓:	
DOB 生日: / /	Gender 性別: M 男 / F 女
Street Address 地址:	
Suburb 郊區:	Post Code 郵遞區號:
Home Phone 住宅電話:	Mobile 手提電話:
Email 電子郵件地址:	
Medicare Number 全民醫療保險卡號碼: Reference Number 參考編碼:	Expiry Date 截止日期: ___/_____
Veterans 退伍軍人: Yes 是 / No 不是	DVA Number 退伍軍人卡號碼:
Private Health Fund 健康保險公司名稱:	
Health Fund Membership Number 健康保險會員號碼:	

UNDER 18 YEARS OF AGE (If applicable) 18 歲以下 (如情況符合)

Parent/Guardian Full Name 父母/監護人姓名:	
Parent/Guardian Medicare Number 父母/監護人全民醫療保險卡號碼: Reference Number 參考編碼:	
DOB 生日:	Phone 電話:

NEXT OF KIN 近親聯絡人

First Name 名字:	Surname 姓名:
Phone 電話:	Relation 關係:

REFERRING DOCTOR 轉介醫生

Name 姓名:	Phone 電話:
Address 地址:	

FAMILY DOCTOR 家庭醫生

Name 姓名:	Phone 電話:
Address 地址:	

PHYSIOTHERAPIST 物理治療師

Name 姓名:	Phone 電話:
Address 地址:	

MR JAMES CHIU
MBBS FRACS (orth.)
ORTHOPAEDIC SURGEON

WORKCOVER 職場傷害

Name of Employer 公司名稱:	Phone 電話:
Employer Address 地址:	
Insurance Company 保險公司:	
Injury Date 受傷日期:	Claim Number 案件號碼:
Claim Manager 案件負責人:	Phone 電話:

TAC 交通傷害

Injury Date 受傷日期:	Claim Number 案件號碼:
Claim Manager 案件負責人:	Phone 電話:

<u>門診預約提醒、留言＆電子郵件</u>

Please advise the front desk staff if you do not wish to receive SMS reminders, or any other message or emails. 如果您不希望收到短信提醒或任何其他留言或電子郵件，請通知前台工作人員。

- *I consent to receive SMS reminders, messages and email. 我同意收到*短信提醒、留言或電子郵件。
  __Yes 同意 __ No 不同意

<u>隱私條約</u>

I understand that this practice handles personal information in accordance with the National Privacy Principles enshrined in the Privacy Act 1988 (Commonwealth) and as outlined in the Privacy Statement. 我理解此診所是根據 1988 年的隱私法(Commonwealth)所規定的國家隱私法則與診所隱私聲明原則來處理私人資訊。

- *I consent to the handling of my information by this practice for the purpose of providing quality health care, administrative billing purposes and communication with other treating allied health professionals e.g. physiotherapist. 我同意此診所為了以提供優質的醫療保健、費用文書管理和與其他合作治療的專業醫療人士溝通之目的來處理我的資訊，例如物理治療師等。* ***__Yes 同意 __ No 不同意***
- *I also give permission for medical information to be obtained from any other source in order to help with my treatment. 我同時也允許此診所為了協助我的治療之目的，而從其他出處取得我的醫療紀錄。*
  __Yes 同意 __ No 不同意

<u>付款條約</u>

I understand that this practice accepts bank transfer, Visa, MasterCard, and bank cheque only (personal cheque and Amex are NOT accepted). Full payment for the initial consultation is required at time of consultation. WorkCover and TAC patients are responsible for paying the full private fee of the initial consultation. A receipt will be issued and provided to you to claim reimbursement from your employer, WorkCover insurer or TAC. Please be aware there may be a small gap between this fee and the amount refunded by the employer, WorkCover insurer or TAC.

Any subsequent appointment(s) will be billed directly to the employer, WorkCover insurer or TAC, provided the claim has been formalised and our practice has been provided with relevant details. 我理解此診所只接受銀行轉帳、Visa 、 MasterCard 與銀行支票 (診所是不接受個人支票與 Amex 的)。初診諮詢門診費用需要當天全額支付。職場傷害或交通傷害的病患需要負責支付全額的初診私人費用，診所會提供收據發票。看診者可以依據發票向雇主、公司保險或交通事故委員會申請初診費用補償。我們的費用與退款金額在某些情況下也許會有微小差額。初診之後的看診費用則會直接向雇主、公司保險或交通事故委員會開帳單申請，其前提是案件號碼已經正式確認下來，同時案件資訊也提供給到診所。

- *I consent to the above payment policy.* ***__Yes 同意 __ No 不同意***

Signature 簽名: _____ Date 日期____/_____/_____