

# CMP PATIENT INFORMATION

Please read through the following information carefully and sign to indicate you understand and agree to these policies.

## Fees

Campbell Medical Practice is a private billing practice. All fees are payable at the time of consultation. Telehealth appointments are charged at the same rate as face-to-face appointments.

## Late Arrival

More than 5 minutes late to a scheduled appointment means you've missed your appointment, you will not be able to see the doctor and your appointment will be rescheduled.

## Non-Attendance

If you miss an appointment this will be noted in your file and the following fees will be charged: **Standard \$50, Long \$85, Extended \$110**. Please note that fee will need to be paid BEFORE another appointment can be made.

## 24hr Cancellation Policy

We require 24 hours' notice to cancel or reschedule any appointments. Failure to do will attract the following fees: **Standard \$50, Long \$85, Extended \$110**.

## Privacy Policy

Campbell Medical Practice may be required to collect personal information about you (or your child/dependent). Your personal health information may be disclosed to others involved in your healthcare, such as other doctors and health care providers. Further information on how Campbell Medical Practice collects and uses your health information can be found in our privacy policy, available at front reception.

## Emails

Unencrypted email is not a secure form of communication. There is some risk that individually identifiable health information may be misdirected, disclosed to or intercepted by unauthorised third parties. If you accept these risks, please consent us below. You may also consent to emails being sent from us to referring practitioners, such as referrals and other health information as required.

### Please check the boxes:

- I accept the risk and consent to receiving information via email. I understand I can withdraw my consent at any time.
- I accept the risk and consent to my referrals and other health information (only as needed) being sent to a referring practitioner by email. I understand I can withdraw my consent at any time.

## CONSENT

By signing this form, I acknowledge the above policies of Campbell Medical Practice:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(Patient / Parent / Guardian)

Pt Name: \_\_\_\_\_ DOB: \_\_\_\_\_