lumina

CONSENT FOR DATA COLLECTION

Do you consent to Lumina holding your and your child's personal information?	**Yes**	**No**
Patient consent for data collection (if you are a patient aged 16+ years and capable)	**Yes**	**No**

By providing us with your / your child or ward's information, you consent to us holding that information and confirm that the information you are providing to us is true and accurate. Lumina Kids' Brain and Mind Clinic complies at all times with Australian Privacy law and principles. We will not disclose your information to third parties without consent, except as part of your care and will only do so to healthcare professionals or their clinic staff, or government agencies (such as Medicare) as part of providing your care.

All our employees and medical specialists/healthcare providers working through Lumina facilities are under a strict duty of confidentiality, and privacy practices are adhered to. Under Australian Privacy law we will destroy your information after a patient turns 25 or 7 years from the last contact (whichever is later) if you have ceased using our Services. You can ask to be removed from our database and we will delete your information, except where we are required to retain such information by law, for example, for Medicare claims audit purposes.

You have the right to access the information that Lumina holds about you. You may contact us by writing to the Privacy Officer at reception@luminamedical.com.au, or at Suite 1, 12-18 Tryon Road, Lindfield NSW 2070.

If either question is answered 'No', please do not continue. Speak with Reception at Lumina.

FINANCIAL CONSENT

I confirm that I have been informed of and accept the fees payable for my / my child's visit	**Yes**	**No**

By confirming your acceptance, you agree to paying the service fee owing for your visit and contacting Medicare if they do not pay the expected rebate. Health funds do not usually pay benefits for outpatient specialist visits – please talk to your health fund to confirm.

If you have not been informed of or accept the fees payable for your visit, please talk to Reception.

PATIENT INFORMATION

First name Last name

Gender Date of birth

Street address Postcode

Phone Email

Medicare #
(10 digits)

Individual #
(1 digit)

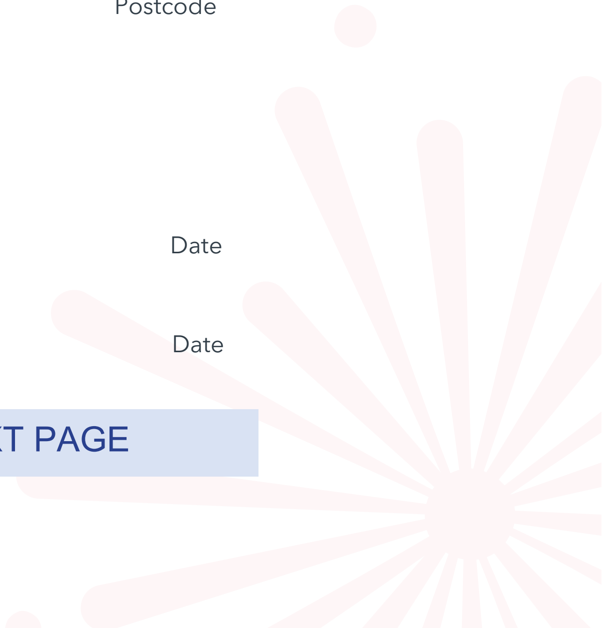
Expiry date

Patient signature
(If aged 16+years and capable of consent)

Date

Parent signature

Date



PLEASE CONTINUE ON NEXT PAGE

PRIMARY ACCOUNT HOLDER (THE PERSON THAT MEDICARE REBATES WILL BE PAID TO)

First name Last name

Gender Date of birth

Relationship to patient

Street address Postcode

Phone Email

Medicare # (10 digits) Individual # (1 digit) Expiry date

Acct holder signature Date

ADDITIONAL ACCOUNT HOLDER (IF REQUIRED)

First name Last name

Gender Date of birth

Relationship to patient

Street address Postcode

Phone Email

Medicare # (10 digits) Individual # (1 digit) Expiry date

Acct holder signature Date

THANK YOU AND WELCOME TO LUMINA