urology associates

Phone 03 355 5129
reception@urology.co.nz
132 Peterborough St
PO Box 917
Christchurch 8140
Healthlink urolasso
www.urology.co.nz

Registration Form

This form is part of your clinical records. Please print clearly

Please Select Title

Surname _____ First/Middle Name(s) _____

Date of Birth ____/____/____ Preferred Name _____

◯ Female ◯ Male ◯ Gender Diverse

Phone Numbers Mobile _____ Home _____ Work _____

Please be aware that some communications will be sent via text messaging to your mobile phone.

Email _____

Email address for financial correspondence *(if different)* _____

Please be aware your Email address will be used for health related and financial correspondence.

Residential Address _____

Postal/Billing Address *(if different)* _____

Do you have any spiritual or cultural needs you would like us to be aware of?

_____

_____

Occupation _____

Ethnicity _____

Please note the ethnicity that most closely matches your culture and beliefs e.g. NZ European, NZ Māori, Chinese.

Name of General Practitioner _____ Referring Doctor _____

Name of Medical Centre _____

Emergency Contact *(or next of kin)* Name _____ Relationship _____

Phone Numbers Mobile _____ Home _____

Are you taking any of the following medications? *(Please tick the boxes that apply)*

Warfarin, Coumadin® or Marevan®	☐ Yes	Ticagrelor	☐ Yes	Prasugrel	☐ Yes
Dabigatran or Pradaxa®	☐ Yes	Apixaban	☐ Yes	Rivaroxaban	☐ Yes
Dipyridamole or Persantin®	☐ Yes	Clopidogrel	☐ Yes	Aspirin	☐ Yes
Enoxaparin or Clexane®	☐ Yes				

Other anticoagulant/blood thinner ☐ Yes *(please specify)* _____

Are you diabetic? ◯ No ◯ Yes *(If yes and you require medication for this please specify)* _____

Are you allergic to any medications? ◯ No ◯ Yes *(If yes, please specify)* _____

Multidrug Resistant Organisms

Have you been hospitalised or worked in a health care facility in New Zealand or overseas in the last six months?

◯ No ◯ Yes *(If yes, please specify when and where)* _____

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Terms and Conditions for Fees

Do you have Health Insurance? ◯ No ◯ Yes

Insurance Company _____ Membership Number _____

Is this referral for an ACC claim? ◯ No ◯ Yes ACC Claim Number _____

For insurance claims, please forward all invoices promptly to your insurance company to enable them to process the claim. Co-payments must be made immediately after notification of part payment by your insurance company.

Please note: Urology Associates do not send invoices directly to insurance companies.
Liability for payment of all invoices remains with the account holder.
Payment at time of service would be appreciated and may be made by cash, EFTPOS, Visa or MasterCard.
Accounts are due for full payment within 7 days of invoice date.
Please contact us should you have any concerns regarding your account.

Cancellation Policy

Please be aware that we ask you to provide at least 48 hours notice when cancelling or rescheduling appointments. Failure to attend an appointment will incur a $100.00 administration fee.

Privacy

We value your privacy. We collect, store, and use your personal information pursuant to our Privacy Policy and the Health Information Privacy Code 2020.

- Your personal information is collected, used and disclosed by Urology Associates and our Allied Health Professionals for the purposes of providing you with care and treatment, and for administration.
- We take steps to prevent unauthorised or inappropriate access to your personal information.
- Failure to provide us with your personal information may compromise your care and may prevent us from providing services to you.
- You have the right to access and request the correction of your personal information by contacting us at the address listed on this form.
- Urology Associates may share details of your account(s) with your insurance company for the purpose of evaluating your medical insurance claims(s) where you provide us with consent to do so.

Disclosure of Financial Interest

Your treatment may involve referral to a private hospital for surgery or referral for other investigations.

Surgeons at Urology Associates operate at a number of South Island hospitals, including Forté Health Ltd in Christchurch. Your surgeon at Urology Associates may hold a financial interest in Forté Health Ltd. Your surgeon will discuss any surgical options with you and will recommend the facility that best suits your needs, considering the availability of any suitable alternative facilities. Your surgeon may hold a financial interest in Reform Radiology Ltd, to which you may be referred. You are not required to accept any referral and the primary concern of your surgeon will always be ensuring that you receive the highest standard of care.

Consent to transfer of patient records

In the event of further treatment (urgent or routine) required to be undertaken by another medical provider, Urology Associates may be requested to transfer part or all of your medical records. This process is undertaken to aid with accurate and efficient medical treatment.

If you do not wish this to happen, please discuss this further with your Urologist.

Patient Agreement

This agreement applies to all Urology Associates businesses.

- I understand this information is being collected and held by Urology Associates Ltd to assist with my medical treatment and care. I understand de-identified data from my records may be registered into local, national and international databases for the purpose of improving clinical care.
- I understand details of my clinical notes may be shared with my insurance company or ACC for the purpose of evaluating my claim(s) where applicable.
- I agree to settle accounts in full within 7 days of the invoice if the account is being paid personally or prior approval has not been obtained from my insurer. I will settle any outstanding balance if services are not fully covered by insurance or ACC.
- Any account not paid within our normal terms will be handed to our debt collection agency. All costs associated with the collection will be added to the account.
- I have read and understood the Terms and Conditions for Fees and I agree to abide by them.
- I have read and understood the Disclosure of Financial Interest.

Signature _____ Date ____ /____ /____

(By patient if over 16 years of age, or parent/legal guardian if under 16)

Details of Parent(s)/Guardian if signing on behalf of a patient under 16 years of age

Name _____ Relationship _____

Email _____ Contact Phone _____

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