vascular health group
Gentle Attentive Complete Vascular Care

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PRIVACY POLICY & CONSENT

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below. This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.

- I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

- I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

- I understand that if my information is to be used for any other purpose other than set out above; my further consent will be obtained.

- **I consent to** the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

Cancellation and No Show Policy

If you are unable to attend the appointment, please contact us to cancel or change the appointment time. A cancellation fee and no show fee (prices listed below) will be applied for appointments cancelled with less than 48 hours notice.

Consultation Cancellations: A cancellation fee of $63

Bulk Billed Consultation and Ultrasound Cancellations: full appointment fees will be charged

Ultrasound appointments: 50% of the fee

Procedure Cancellations:

- A cancellation fee of $282 (1/2 hour session) and $435 (1 hour) will apply for Ultrasound Guided Sclerotherapy,
- $357 (1 hour session) and $230 (1/2 hour session) for Sclerotherapy
- $524 for Phlebectomy

Endovenous Laser: Your deposit of the Facility Fee ($500 for inpatients) applies as a cancellation fee if this procedure is cancelled within two weeks of your laser treatment. (Deposit may be used towards your procedure if re-booked within 6 months).

Please tick if you DO NOT consent

☐ To clinical photographs, which may be taken to assist in my care and documentation of before and after treatment.

☐ To the use of these photographs (de-identified) for educational/research purposes

☐ To the use of clinical information (de-identified) for educational/research purposes

☐ To the use of email when communicating with others involved in your health care, including treating doctors and specialists outside this medical practice (I understand email is not a secure nor encrypted form of communication, however, it allows VHG to deliver patient information expeditiously, reduces waste and its impact on the environment and paper mail is slow, less reliable and costly). We understand, however if your preference is for us to use paper mail.

Signed:..... Date:.....

Patient Name: ..... Date of birth:.....

Address: .....