

GENESIS MEDICAL CONSULTING

Specialist Psychology & Mental Health Practices

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PATIENT INTAKE FORM

Strictly Confidential Clinical Document
Compliant with Australian Privacy Principles

1. OFFICE USE ONLY | Administrative Intake Tracking

Patient Ref / File No:

Intake Date:

DD / MM / 20

Treating Clinician:

☐ Dr Raymond Tint Way

☐ A/Prof Prashanth Mayur

☐ Dr Yajuvendra Bisht

☐ Dr Rasiah Yuvarajan

☐ Prof Thiagarajan Sitharthan

☐ Other: _____

2. PERSONAL DEMOGRAPHICS | Client Identification & Cultural Identity

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other: _____

Preferred Name: _____

Surname (Legal): _____

Given Names (Legal): _____

Date of Birth: _____ (DD/MM/YYYY)

Preferred Pronouns: _____

Sex at Birth: ☐ Male ☐ Female ☐ Prefer not to say

Gender Identity: ☐ Man/Male ☐ Woman/Female ☐ Non-Binary

☐ LGBTQ+ / Other Identity (Specify: _____) ☐ Prefer not to say

Indigenous Status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander ☐ Neither

Residential Address: _____

Suburb: _____ State / Postcode: _____

Mobile Phone: _____ Home / Work Phone: _____

Email Address: _____ Occupation: _____

Marital Status: _____

3. BILLING, MEDICARE & THIRD-PARTY INSURANCE | Medicare & Compensable Claims

Medicare Number: _____ Ref No: _____ Expiry Date: _____ (MM/YY)

Private Health Fund: ☐ Yes ☐ No | Fund Name: _____

Member / Policy No: _____

Third-Party Compensable Claim Screener:

Is this consultation related to a WorkCover / Workers' Compensation or Motor Vehicle Accident (CTP) claim? ☐ YES ☐ NO (If YES, complete details below. If NO, proceed to Section 4 on reverse)

Claim Type: ☐ Workers' Compensation (WorkCover NSW) ☐ CTP / Motor Vehicle Accident ☐ Other

Insurer Name: _____ Claim / Case Number: _____

Date of Injury: _____ Case Manager Name: _____

Case Mgr Phone: _____ Case Manager Email: _____

Please turn over to complete Medical Background, Cancellation Policy, and APP Privacy Consent →

4. EMERGENCY CONTACT / NEXT OF KIN | Authorized Contact in Medical Emergencies

Full Name: _____ Relationship to Patient: _____
Primary Phone Number: _____ Alternative Contact / Email: _____

5. MEDICAL & REFERRAL BACKGROUND | Inter-professional Care Coordination

Referring GP / Specialist: Dr _____ Practice Name: _____
Practice Address: _____ Phone / Fax: _____
Prior Psychiatric or Psychological Care: Have you previously seen a psychologist, psychiatrist, or mental health clinician? ☐ Yes ☐ No
If YES, Previous Clinician / Service: _____ Approx. Date of Last Visit: _____
Preferred Pharmacy / Chemist (for e-prescriptions, clinical orders, and pharmacotherapy coordination):
Pharmacy Name & Suburb: _____ Phone Number: _____
Pharmacy Fax / Email Address: _____

6. FINANCIAL POLICY & BOOKING TERMS | Billing Schedule & Cancellation Agreement

Electronic Invoicing: All billing communication, fee schedules, and tax invoices are issued electronically via email by our administrative team.

Payment Schedule:

- **Initial Consultations:** Payment must be settled in full prior to the consultation commencing to secure the clinical appointment.
- **Follow-up Appointments:** Fees are strictly payable immediately following the completion of the consultation.
- **Telehealth Sessions:** Consultation fees must be finalized prior to the scheduled appointment start time.

Attendance & Cancellation Policy: Once an appointment time is reserved, the client holds sole responsibility for attending promptly. We understand that circumstances can change. If you are unable to attend your appointment, we kindly ask that you provide at least **24 hours' notice**.

Cancellation & Non-Attendance Fees Notice:

- For appointments cancelled with less than 24 hours' notice, a cancellation fee of **\$200 for an initial consultation** or **\$120 for a follow-up consultation** may apply.
- If you do not attend your appointment without prior notice, a fee of **\$300 for an initial consultation** or **\$180 for a follow-up consultation** may apply.
- Cancellation and non-attendance fees are **not eligible for a Medicare rebate**.
- We understand that emergencies and unexpected circumstances can occur, and the cancellation fee may be waived at the discretion of the practice in exceptional circumstances.

⚠ **Medical Reports & Documentation Notice:** Standard consultation fees cover direct clinical assessment, diagnosis, and treatment only. If the client, patient, or an authorized third party requires a formal medical report, comprehensive assessment summary, or clinical letter from the treating doctor or clinician, **additional professional fees will apply, including Goods and Services Tax (GST)**. Medical reports require dedicated clinician time outside scheduled appointments and are not covered or subsidized under Medicare. Written fee estimates are available on request, and report fees must be settled prior to document release.

7. PRIVACY NOTICE, DATA RETENTION & CONSENT | Compliance with Privacy Act 1988 (Cth)

Australian Privacy Principles (APP) Collection Notice: Genesis Medical Consulting collects sensitive personal and health information to provide comprehensive psychological and psychiatric care. Information collected includes clinical histories, consultation notes, diagnostic assessments, and correspondence with other treating practitioners (such as your GP). Information will only be disclosed: (a) to your referring medical doctor or other designated health practitioners for continuity of clinical care; (b) where subpoenaed or required by law/court order; (c) where there is a reasonable belief that disclosure is necessary to lessen or prevent a serious and imminent threat to your life, health, or safety, or that of another person; or (d) to regulatory authorities for statutory Medicare/audit compliance.

Health Record Retention Schedule: In accordance with the *Health Records and Information Privacy Act 2002 (NSW)*, Australian Digital Health Agency standards, and professional registration guidelines, your medical records will be retained securely for a minimum of 7 years from the date of the last consultation, or in the case of clients who attended as minors, until the client attains 25 years of age. All records are maintained in encrypted, cloud-secured clinical practice management systems with restricted role-based access.

PATIENT ACKNOWLEDGEMENT & INFORMED CONSENT:

I have read, understood, and agree to the Financial Policy, Payment Schedule, and Cancellation / Non-Attendance Policy. I acknowledge that requests for medical reports or documentation attract additional professional fees including GST. I consent to the collection, storage, use, and clinical disclosure of my health information as outlined in the Privacy Collection Notice under the *Privacy Act 1988 (Cth)*. I confirm that the demographic, insurance, and medical details provided are accurate to the best of my knowledge.

Patient / Legal Guardian Signature: _____ Date: _____

Printed Full Name: _____ Relationship: _____
(if Guardian)