



MR NEIL BERGMAN MBBS FRACS FAOrthA
ADULT RECONSTRUCTION &
JOINT REPLACEMENT SURGERY
PROVIDER NO: 33633BJ

ORTHOPAEDIC SPECIALISTS OF MELBOURNE
WARRINGAL MEDICAL CENTRE
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NAME Mr/Ms/Mrs/Miss/Dr.....
Surname First Middle

ADDRESS..... PHONE (Home).....
.....P/CODE..... (Work).....

PARENT/GUARDIAN – Name (for accounts) and Address (if different from above): (Mobile).....
(if applicable)

..... DATE OF BIRTH..... AGE.....

MEDICARE CARD NO..... REF NO.....EXPIRY DATE.....

PRIVATE HEALTH INS: Health fund.....Member No.....Level of cover.....

DEPARTMENT OF VETERANS AFFAIRS VX Number.....Card Colour.....

ALLERGIES (please list).....

REFERRING DOCTOR.....

FAMILY DOCTOR (if different from the referring doctor).....

ADDRESS:

IMPORTANT

- **FEE POLICY** Have you read Mr Bergman’s fee policy? A copy can be obtained from the receptionist.
- **PRIVACY POLICY** - From 12/3/2014, the Privacy Act 1988 has been amended by the Privacy Amendment (Enhancing Privacy Protection) Act 2012. The Australian Privacy Principles (APP) require that fully informed voluntary consent is obtained before or as soon as practical after the collection of health information. Medical care requires full knowledge of patient health information by all members of a medical team. Your information may be shared with other health providers from time to time. This may include referring doctors, pathology laboratories, radiology practices, anaesthetists, other health providers and debt collection agencies. Some information may also be provided to Medicare, and Private Health funds, if relevant, for billing and Medicare rebate purposes. Health information may be used for “secondary purposes” such as auditing surgical results, clinical research etc. These activities should be a normal part of good surgical practice. Record keeping for orthopaedic surgery may also include radiographs and clinical photographs. The privacy of individual patients is strictly maintained when reporting results of audits or research to the profession. You may request access to your records. A copy of our privacy policy is available from the receptionist. Please discuss concerns about the privacy of your personal information with Mr Bergman

- I.....(name), have read and understood the fee policy and the outline of the privacy policy, and consent to information, Xrays and photographs being used for the “secondary purposes” of Audit and Research by Mr Bergman and his associates. I also give my permission to be contacted for clinical research projects, understanding that it is my decision whether or not to participate and that my treatment will not be influenced by this decision.

Signature..... (If guardian, relationship to patient.....) Date...../...../.....