UROLOGY SA
Dr Jehan Titus & Dr Jimmy Lam
St Joseph's Cottage, Calvary Hospital
89 Strangways Terrace
North Adelaide SA 5006
ABN: 60 435 211 679

PHONE: 08 7231 0433 FAX: 08 8267 1821 EMAIL: manager@urologysa.com.au

NEW PATIENT PACK

DR JIMMY LAM
DR JEHAN TITUS

(INDICATE WHICH DR REFERRAL IS FOR BY TICKING)

PLEASE COMPLETE
AND RETURN TO THE MANAGER
PRIOR TO AN APPOINTMENT TIME BEING ALLOCATED
(email: manager@urologysa.com.au)

Please contact our rooms if you have any queries regarding your appointment.

Our friendly reception staff are available to assist you between 9:00am – 5:00pm Monday to Friday

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

CONFIDENTIAL PATIENT INFORMATION

PERSONAL DETAILS:

Title: Dr / Mr / Mrs / Miss / Ms / Other		Date of Birth:
Surname:		Home Phone:
Given Names:		Work Phone:
Preferred Name:		Mobile Phone:
Marital Status: Defacto / Divorced / Married /Same Sex Partner / Single / Widowed		Email:
Address:		
Suburb:	Postcode:	Appt Reminders via SMS? Y / N
Postal Address:		
Suburb:	Postcode:	Are you a Diabetic? Y / N
Interpreter Required:	Y / N	Language:

FINANCIAL INFORMATION:

Medicare Number:	Exp Date:	Card Ref No:
Private Health Fund	Member No:	Level of cover: Hospital / Extras
DVA Number:	Gold / White	
Pension card:		Expiry Date:

REFERRAL INFORMATION:

Referring Dr:	
Address:	Is this Dr your usual GP? Y / N
Phone no:	
Usual GP (if different from referring Dr)	
Address:	
Phone no:	

NEXT OF KIN DETAILS:

NOK Name:	Home phone:
Relationship:	Mobile phone:

Patient Signature: _____

PATIENT NAME: **DOB:** **DATE:**

PATIENT HEALTH QUESTIONNAIRE

Current medical conditions:

.....

.....

.....

.....

List any previous surgery:

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.....

List any allergies:

.....

.....

List family history of serious illness / disease:

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.....

Do you smoke? **Y / N** If "Yes" how many cigarettes per day? _____ For _____ years

If you an ex-smoker how long ago did you quit? _____ Cigarettes per day prior to quitting? _____

Do you drink alcohol? **Y / N** If "Yes" how many glasses _____ per day / week / infrequent

How much caffeine do you consume per day (per cup) **Coffee** _____ **Tea** _____ **Cola** _____

EMPLOYMENT HISTORY

Employed □ Unemployed □ Retired □

What is / was your occupation.....

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

PATIENT CONSENT INFORMATION

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 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:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclose 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.
- Disclose to doctors covering for our doctors when on leave, for the purpose of patient care.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management.

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 provided to me.

I am aware of my rights to access the information collected about me, except in some circumstances where access might legitimately 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 purposes, other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purpose set out above, subject to any limitations on access or disclosure that I notify this practice of.

We may also request information from hospitals or other medical practitioners regarding previous medical history and/or operation and admissions to hospital, which are relevant to your condition.

I _____ consent to Dr Jimmy Lam or Dr Jehan Titus collecting the above information.

PATIENT SIGNATURE _____ DATE_____

PATIENT NAME: **DOB:** **DATE:**

PROFESSIONAL FEES

Please note that Medicare does not completely cover the cost of your consultation.

NON-PENSION	**FEES TO PAY ON DAY**
Initial Consultation ** **PLEASE NOTE**: Initial consult fee will be charged for a new problem or if patient has not seen for 1 year	$200.00
CONCESSION CARD HOLDERS Follow up Consultation	$120.00
Initial Consultation ** **PLEASE NOTE**: Initial consult fee will be charged for a new problem or if patient has not seen for 1 year	$180.00
Follow up Consultation	$ 100.00

Our practice asks that all fees for consultations be **paid in full** on the day of your appointment.
A $100.00 admin fee will apply to any accounts not paid in full on the day of your consultation.
These fees are subject to change.

We are happy to send a claim to Medicare on your behalf, or you may take the account and visit a Medicare office for the gap amount.

We accept cash, EFTPOS, Credit Card, bank cheque or Australian Money Order. Unfortunately, personal cheque's cannot be accepted.

Our payment terms are 30 days. Any accounts exceeding this period will be referred Mercantile Credit Management Pty Ltd and a 17% recovery fee and any legal fees involved in the recovery of the payment will be payable by the patient/account holder.

All outstanding accounts must be paid prior any future date of surgery.

IMPORTANT: If you do not wish to keep any booked appointments please advise the secretary at least 24 hours before the appointed time, so that we may allocate that time to another patient. Should you not give 24 hours notice, a full fee will apply for non-cancellation.

PATIENT DISCLAIMER

I have read and agree to the above terms regarding the professional fees.

_____ _____
PATIENT NAME PATIENT SIGNATURE

_____
DATE

PATIENT NAME: **DOB:** **DATE:**

WHAT TO EXPECT AT YOUR INITIAL APPOINTMENT

Appointment guidelines
Generally speaking you should allow 30 minutes for your first consultation. Subsequent appointments are allocated 10-15 minutes. Please complete the enclosed paperwork prior to your appointment and return to the Receptionist. There may be times where our doctors are running late of schedule. If time is an issue for you please feel free to call our office 30 minutes prior to your appointment for confirmation.

If asked to attend your appointment with a full bladder.
The urodynamic test is performed to measure the speed or rate at which you pass urine and your bladder muscle strength. The nurse will apply a cuff (similar to a blood pressure cuff) to the penis, the cuff will then be inflated and you will be asked to empty your bladder into a funnel.
The flow test is a non-invasive procedure that requires you to empty your bladder into a pot under a funnel. A machine will analyse your flow rate and produce a report. Our doctors may also perform an ultrasound of your bladder in their rooms. This is performed to assess your lower urinary tract and voiding function. These tests require you to attend your appointment with a full bladder and you will be given instructions for this when your appointment is made. There will be no out of pocket expense for either of these tests as they are bulk billed to Medicare.

Pain prior to appointment
If you are experiencing significant pain and feel that you are not coping at home (e.g. patients with kidney stones) please either contact our office during business hours (9am-5pm) or alternatively present to the Calvary Wakefield Emergency Department where the Drs will examine you and contact one of our doctors if necessary.

GUIDE TO SURGICAL EXPENSES

For Privately Insured Patients - General
Our doctors bill their accounts directly to your private health fund. However, *some* procedures will incur a "Gap" fee that will be payable no less than 48 hours prior to the procedure. You will be given an invoice for this when the surgery is booked. This amount is above what your health fund has agreed to pay for your procedure and is not able to be claimed by either Medicare or your health fund. Please contact our office for further information. You may also incur an out of pocket anaesthetist fee.

For Privately Insured Patients – daVinci Robot Radical Prostatectomy
As this procedure is only offered at the St Andrew's hospital, all fees will be billed directly to your private health fund. However there will be a non-rebatable gap fee for the assistant and for Dr Lam. In some instances there is a hospital consumable fee, which you will be advised prior to leaving our rooms. This consumable fee should be paid through our office. You may also incur an out of pocket anaesthetist fee.

Public patients
Dr Lam has a public hospital appointment at the Repatriation General Hospital and Royal Adelaide Hospital. Dr Titus has a public hospital appointment at the Royal Adelaide Hospital - If you wish to be treated at a public hospital you will be placed on the waiting list at either of these facilities as appropriate.

Public patients – self-funding
If you wish to self fund your procedure/admission to a private hospital a quote can be arranged by our office. However, the surgery will remain pending until full payment is received. Medicare will provide a rebate for a portion of these expenses. You may also incur an out of pocket anaesthetist fee.

Overseas Students/Visitors with private health insurance
Full payment is required for all consultations (on the day) and procedures (no less than 48 hours prior). A receipt will be given which can then be forwarded to your health fund for reimbursement.

PATIENT DISCLAIMER

I have read and agree to the above terms regarding the Surgical Expenses / Professional Fees.

NAME:_____

SIGNATURE:_____ DATE:_____