



Patient Information - Paediatrics

Patient Details (of Child)

Full Name of Child (as per current Medicare card):

Child's Date of Birth: / /

Child's Sex (or preferred gender identity/pronoun):

Child's Residential Address:

.....

Child's Medicare Card Number:

Place on Card (number before child's name): Expiry Date: / 20.....

Emergency Contact for Child (name, number and relationship):

.....

Account Holder (Parent/Guardian)

Your Full Name (as per current Medicare card):

Your Relationship to Child:

Your Date of Birth (for billing): / /

Your Residential/Postal Address (if different from above):

.....

Your Email address:

Your Phone Number:

Your Medicare Card Number:

Place on Card (number before your name): Expiry Date: / 20.....

Please list the details below of **BOTH parents/ALL guardians** (this may include step-parents etc).

Important Note: Both parents are entitled to receive all medical correspondence, unless there is a court order specifying otherwise. If both parents' names are not included below, **you will need to please provide a copy of the relevant court documentation.**

Name	Contact Number	Contact Email	Relationship to Child	I authorise Intuition Private to discuss/release information to this person:
				Y / N
				Y / N
				Y / N
				Y / N

By signing this I agree and understand:

- **Use of AI Scribes:** To improve your healthcare experience, our clinic employs AI scribes to document consultations. This technology allows for precise notes and better communication of your medical needs. Rest assured that all data is handled with the utmost care and confidentiality. If you have any questions or would like more information about how this works, we're here to help. Unless you opt out, you acknowledge and accept the use of AI scribes during consultation.
- **Communication Consent:** I authorise Intuition Private to send me SMS and email updates regarding my child's care and appointments.
- **Acknowledgment of Services:** I understand that Intuition Private offers a variety of services, including Obstetrics, Gynaecology, Ultrasound, and Paediatrics. While some items listed in our Patient Care Agreement may not apply to the specific service my child is receiving, it is essential that I acknowledge this information fully.
- **Representation:** I acknowledge that I am accepting this Patient Agreement on behalf of myself, my dependent child, or as a caregiver.
- **Consultation Fees:** I understand that any procedures performed during consultations may incur additional charges, unless otherwise stated. This includes services such as vaccinations, developmental assessments, and minor procedures. I am aware that not all pathology samples will be bulk billed, and I will be responsible for any invoices received.
- **Payment Authorisation:** I authorise Intuition Private to charge my registered credit card for applicable fees. Please note that a minimum credit card surcharge will be added to all invoices settled by card. Cash payments are also accepted if preferred.
- **Emergency Contacts:** In case of an emergency, I authorise listed next of kin and/or either parent/caregiver to be contacted and to discuss my child's medical and billing information, if necessary, **unless provided court documents state otherwise.**
- **Medical Information Release:** I consent to the release of my child's medical information to other healthcare providers involved in their care.
- **Billing Communication:** I authorise Intuition Private to discuss my child's information with Medicare and my health fund regarding claims on my behalf. I also consent to any bulk-billed telehealth consultations, which will be charged at the discretion of the treating doctor, as indicated by my signature below.
- **Previous Medical History:** I permit Intuition Private to request copies of previous medical treatments and history, I grant Intuition Private access to digital medical records that are relevant to treatment, including X-ray results, pathology reports, and other such electronic records.
- **MyHealth Record Sharing:** Unless I opt out, I permit Intuition Private to share my child's clinical records through MyHealth Record.
- **Out-of-Pocket Expenses:** If I am not privately insured or Medicare-eligible, I agree to be responsible for any out-of-pocket expenses as a self-funded patient.
- **Appointment Availability:** I understand that due to the on-call nature of the doctors' work, my child's doctor may be unavailable for their scheduled appointment. I will receive notice via SMS or phone call if this occurs.
- **Responsibility for Additional Costs:** I acknowledge that Intuition Private's fees do not cover services provided by other doctors or facilities involved in my child's care (e.g. anaesthetists, pathologists, hospital admissions) or any related costs during hospital stays. It is my responsibility to inquire about these costs prior to admission.
- Appointments for children in the care of the **Department of Communities and Justice (DCJ)** follow a separate fee structure from our standard paediatric services. Please notify our administration team or the consulting doctor if your appointment pertains to a DCJ child. By doing so, you acknowledge and agree to the applicable DCJ appointment fee.

Patient Name:

Parent/Carer Name:

Parent/Carer signature: **Date:** / /

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