PERSONAL INFORMATION

Name: _____

Address: _____

_____Postcode:_____

Phone: _____DOB: _____

GP or Referring Doctor Name: _____

Practice Address: _____

Phone: _____

NEXT OF KIN CONTACT DETAILS

Name: _____ Relationship:_____

Phone: _____

CONSENT

Please initial boxes to authorise consent

☐ I authorise Sarah Smith to contact my/my child's GP, Paediatrician and/or other medical professionals as appropriate to discuss my/my child's dietetic management.

☐ I understand payment is due at the time of appointment and that payment may be made by cash, credit card or EFTPOS. I understand fees are $145 for initial consultation (60 minutes) and $85 for review consultations (30 minutes) or $125 for extended review consultations (60 minutes).

☐ I understand that there are no fees for sessions that I cancel or change one or more days prior to a scheduled appointment. Sessions cancelled on the day of the appointment, but prior to the appointment are charged fifty per cent of the session fee. Sessions missed without any prior notice of cancellation are charged the full fee.

☐ I understand that personal information about myself/my child are collected and kept as part of the dietetic consultation. This is a necessary part of the dietetic assessment and enables effective treatment. I understand these records are securely stored by Bayside Dietetics. I understand these records are accessible only to Bayside Dietetics and can only be released with my written permission, except where (a) it is subpoenaed by a court; or (b) failure to disclose the information would place me/my child or another person at serious and imminent risk. Although rare, if such a situation does occur, Sarah Smith will make every effort to discuss this with me before taking any action.

Signature: _____

(Signature of parent, guardian or authorised representative when required)

Date: _____