Kelly Thompson – Occupational Therapist

Privacy Information and Consent Form

PRIVACY INFORMATION

ABLE Therapeutic Services recognises the importance of keeping the personal information that you entrust to us private and confidential. As a client of **ABLE Therapeutic Services**, certain personal information will be required to establish and maintain your treatment plan, including health information.

Collection of information

ABLE Therapeutic Services will collect information which is necessary to properly assess and treat you and may include:

- Full medical history
- Family medical history
- Contact details
- Medicare, NDIS and private health fund details
- Billing/account details.

There are instances where **ABLE Therapeutic Services** may need to collect information from other sources such as NDIS, Support Coordinators, Local Area Coordinators, suppliers, medical practitioners, allied health professionals such as physiotherapists, psychologists, Speech Pathologists, Service providers and may be from hospitals. **ABLE Therapeutic Services** therapists, Allied Health assistants and administrative staff may be involved in the information collection.

Use and Disclosure

With your consent, **ABLE Therapeutic Services** will use and disclose your information for purposes such as:

- Account keeping purposes
- Referral to other medical or health care services
- The management of our practice
- Advice of recommendations, treatment options and communication with your care team

ABLE Therapeutic Services Privacy Policy

If you require further information regarding this privacy statement, **ABLE Therapeutic Services** has a written privacy policy that reflects the Federal Privacy Act 1988 (and amended Privacy Act 2000).

CONSENT

I consent for **ABLE Therapeutic Services** to collect, use and disclose my personal information as outlined above.
I authorise **ABLE Therapeutic Services** to obtain either verbal or written information in relation to my therapy.

I authorise **ABLE Therapeutic Services** to release information concerning relevant aspects of my assessment, therapy program and discuss that information with representatives of the individuals/agencies included in my health care. If there are specific people you do not want us to communicate to, please list here:

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I have signed a service agreement (if applicable) and also understand it is my responsibility as a client to attend all scheduled appointments, and that I will need to contact **ABLE Therapeutic Services** to reschedule an appointment I have cancelled or did not attend.

Patient name: ……………………………………………………………………………………… Date: ………………………………

Signature: ……………………………………………………………………………………………………

Signature above is of parent/guardian, as patient is under 18 years of age:

Yes ☐ No ☐ Name of person signing on their behalf: ………………………………………………