Vitality Healthcare Medical Centre

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Medicare Bulk Bill Assignment of Benefit Claiming Telehealth Consultation Consent Form

Name:____
Telephone Number: _______________________________ Date of Birth: ________________________
Medicare Number: ____ Reference Number: _________
Address: ____

Technical Aspects and Requirements
I understand that there are some potential problems that might arise in the course of accessing online/telehealth services, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider(s), that the transmission of my information could be disrupted or distorted by technical failures. I understand that if the online/telehealth session does get disconnected, or runs poorly, my provider(s) will contact me via phone to continue our session.
I understand that I am responsible for providing the necessary computer, telecommunications equipment and internet access for my online/telehealth sessions and arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my online/telehealth session.

Privacy Notice:
Your personal information is protected by law, including the Privacy Act 1988, and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim.
Your information may be used by the department or given to other parties for purposes of research, investigation or where you have agreed, or it is required or authorised by law.
You can get more information about the way in which the Department of Human Services will manage your personal information, including our privacy policy at the humanservices.gov.au/privacy or by requesting a copy form the department.
Information about medical/dental expenses for people under the age of 18 may also be disclosed to adults on the same Medicare card, through taxation statements.

I assign my right to benefits to the provider(s) who render the Telehealth services through Medicare as stated below on this form.

Signature:____Date: ____________________________

Staff record use only

Date of service	Provider(s)	Provider number	MBS item number	Staff initial