Northside Health NT

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Thank you for your recent request for an appointment with Dr Jane Chapman MBBS FRACGP

Dr Jane believes the journey of recovery, restoration and re-energising will take time and it is paramount that you invest your time into this journey. Dr Jane cannot do it for you, but she can empower you with the knowledge of how. Lifestyle changes, Nutritional changes, Emotional and Physical awareness, and perhaps the use of Nutritional Supplements, to aide your recovery, will all help on your wellness journey with rejuvenation, energy and improved well-being.

**THE PROCESS:**

To begin this process there are a few documents that require your attention.

* **Health Questionnaire**
* **General Consent Form**
* **Integrated Medicine Privacy & Medical Fees Policy**

(It is important that you read and acknowledge this document).

Please email these completed forms back promptly - no later than 24 hours prior to your appointment.

**General Details:**

**Name ………………………………………………………………………………………………………………………………………………….…….**

**Residential Address ………………………………………………………………………………..………………………………………………….**

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**Email Address ……………………………………………..….…………….…… Best Contact No …………….……………………….…….**

**DOB …..………/…….……/…………….. Aboriginal/Torres Strait Islander Y / N**

**Medicare No ………………………………………..…….……….……….……….. Ref ………….… Expiry …..………… /……..…………**

**Next of Kin …………………………………………………………..……………………. Contact No ……………………………………………**

*Transform to Complete Wellness!*

**HEALTH QUESTIONNAIRE:**

Please list your major health concerns in order of importance and how long have you had each of these?

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Please list your family health history. Please consider any cancer, heart issues, auto immune conditions, mental health/mood issues.

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Please list any childhood health issues you had: (eg asthma, eczema, recurrent respiratory conditions, food intolerances, behavioural issues)

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Please list your current and previous medication usage, including Pharmaceutical medications, remedies, herbal treatments and/or vitamins.

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Are you on any particular diet (Eg Paleo, gluten free, vegetarian, vegan, fodmap, GAPS): if so, how long for:

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What obstacles or beliefs, if any, stand in the way of you recovering your health?

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Your main concern and reason for attending Dr Chapman ………………………………………………………………………………

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Have you had any pathology or blood tests in the last two years? **Yes / No** [please circle which one applies]

Have you had any X-Rays, scans or ultrasounds in the last two years.  **Yes / No** [please circle which one applies]

How did you hear about Dr Chapman?

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*Transform to Complete Wellness!*

**Privacy & Consent Form**

**WON WELLNESS** is required to collect information about you for the purpose of providing a quality service to you. In order to thoroughly assess, diagnose and provide treatment, we need to collect personal information from you. If you do not provide this information, we may not be able to treat you. This information will be used for:

* The administration purpose of running the practice.
* Billing either directly or through an insurer or compensation agency.
* Use within the Practice if discussing or passing your case to another Practitioner within the practice for your ongoing management.
* Disclosure of information to other Health Practitioners outside the practice to facilitate communication and best possible care for you.
* In the case of insurance or compensation claim it may be necessary to disclose and/or collect information that concerns your return to work to an insurer or your employer.

**WON WELLNESS** has a Privacy Policy that is available on request. This Policy contains information on how you may request access to, and correction of, your personal information and how you may complain about a breach of your privacy and how we will deal with such a complaint.

To ensure the process of quality treatment provision, information about your assessment results and progress may be given to relevant other service providers, who are involved in your management. These may include other Doctors, Specialists, Insurers, Solicitors or Employers.

Further to the collection of information the **WON WELLLNESS** requires that you understand:

* Some of the accessory functional pathology tests, performed by independent laboratories may be used as accessory tools to outline treatments and products administered by practitioners at Won Wellness, which maybe outside the parameters of orthodox medicine in Australia
* These tests, treatments and products fall into the category of Natural or Complementary Medicine and Natural Hormonal Medicine including compounded natural hormonal Medicines.
* These individual laboratory tests, treatments and products are supported by empirical knowledge and in many cases by research data.
* That these tests, treatments and products are widely and successfully used by Integrative Medical Practitioners in Medical Centres in Australia and overseas.
* Some diagnostic tests and treatments offered at **WON WELLNESS** are not covered by Medicare or Private Health Insurance Funds.
* All **WON WELLNESS** Practitioners are members and active participants of their Professional Colleges.
* The Complete Wellness Program (HCG Program) is billed as a separate program entity
* The fee structure for INTRAVENOUS THERAPY is entirely dependent on the ingredients of vitamins, anti-oxidants etc. used in the infusion, which is prescribed only by Dr Jane Chapman, on an individual basis.

Due to the unpredictable nature of Health Clinics, Doctors and Health Practitioners sometimes run behind. We regret any inconvenience caused to Patients when your appointment is delayed.

I …………………………………………………………..…………… have read and understand all the information sent from the **WON WELLNESS** and received by me. I confirm that I am attending the **WON WELLNESS** of my own free will and consent and exercise my right to discuss and choose any useful and suitable treatments made available to me. I understand that I will be privately billed for all Consultations with Dr Jane Chapman relating to specialised general practice. I further understand that it is my choice as to what information I provide and that with-holding or falsifying information might act against the best interests of my assessment and therapy progress.

I consent to communication via telephone, SMS and Email. **Y / N**

Signed ……………………….………………………………. Print Name …………………………………….. …..../……./……..….

**Appointment and Fees Structure**

Initial comprehensive evaluation is usually 30 minutes, however if you have an extensive and complicated medical history 45 minute initial appointments are available upon request.

30 minutes **New Patient:** $220 (Medicare rebate item 36, $75.05)

Follow up appointments:

15 minutes: $90 (Medicare rebate Item 23, $38.75).

30 minute: $180 (Medicare rebate Item 36, $75.05)

There may be additional costs such as Supplements, Vitamin Injections, and laboratory expenses for non-Medicare Investigations, such as Saliva hormone testing, Hair Tissue Mineral Analysis, or other investigations.

Practitioner range **Nutraceuticals/Supplements/Complementary** Medications may be advised.

Full payment is expected at the end of each Consultation. Cash, Eftpos and Credit Cards are accepted. Medicare rebates are applicable to your normal Consultation visits and your rebate can be claimed on the day with payment via EFTPOS/Medicare Easy claims. WON WELLNESS stocks and supplies complementary therapies and will receive a profit from the sale of such items. There is no mutual obligation to sell or purchase such items at WON WELLNESS.

**CONFIRMATION & CANCELLATION POLICY –**

**You must confirm your appointment minimum 24 hours prior.**

**If you wish to change or cancel** an appointment, please give **24 hours notice.**

FAILURE to provide notice of non-attendance will incur the full consultation fee.

We consider our time with you as a privilege to help you, and request that you give the same consideration.

Patients who change or miss two appointments for which they fail to give appropriate notice will be no longer

be provided with services at this Clinic.

Please note: there is NO Medicare rebate (refund) associated with broken appointment fees.

I ……………………………………………………………………………………………………………………………………………….……………….…………..

Have read and understand the information as detailed, and agree to the terms as outlined above.

Signed ……………………………………………………………………………………………………………………….. ..………../…………../………….