New Patient Information Form - Dietetics

Please complete this form if you are a new patient to **Melissa Colombo**. If you need any help, our team will be happy to assist you.

Instructions:

1. Please complete all required fields (marked with an asterisk*).
2. Please tick (✔) or mark (✘) in the ◯ for multiple-choice questions.

Who is completing this form?*

◯ I am the patient ◯ I am the patient's parent, legal guardian or substitute decision-maker

Full Name: _____

Patient Details

First name* _____ **Last name*** _____

Preferred name _____ **Date of birth*** _____ /_____ /_____

Email* _____ **Phone** _____

NDIS

Do you have nutrition or dietetics on a NDIS Plan?* ◯ Yes ◯ No

Client Number: _____ **Plan Manager** _____ **Phone** _____

Would you like us to register your provided email for Blossom Women's and Family Dietetics' website to receive email updates from Melissa?* ◯ Yes ◯ No

Additional Information

What do you hope to achieve in your appointment with Melissa?

_____

_____

What are your main nutrition concerns for you / your child?

_____

_____

Do you / your child see any other allied health professionals? ◯ Yes ◯ No *If yes, please provide details:* _____

_____

How did you hear about our Melissa?

◯ Family ◯ Friend ◯ Google / Online Search ◯ Our Website ◯ Social Media

◯ Other: _____

Informed Consent and Service Agreement

I consent to receive care and treatment for ☐myself/ ☐my child from the Practitioner, Ms. Melissa Colombo, Accredited Practising Dietitian (APD) of Blossom Women's and Family Dietetics at Signal Health Tusmore.

Understanding of fees and charges

I understand that:

- I will be charged $240/hr. for the length of consultation time.
- I will pay the consultation fee outright following the appointment.
- I may be required to subsequently claim any Private Health or Medicare rebates thereafter.
- Any NDIS client appointments or NDIS requested reports will be charged as per the hourly rate outlined in the *NDIS Pricing Arrangements and Price Limits 2025-2026*.

Understanding of cancellation

I understand that:

- Cancellations **on the day** of your appointment may incur a **100% cancellation fee.**
- Cancellations **24-48 hours before** the appointment may incur an **80% cancellation fee**.
- **Failure to attend** an appointment without prior notice will incur a **100% cancellation fee.**
- If you are late or your consultation finishes early if you/your child becomes sick or due to an unforeseen reason, the full time of the session will be charged.

Client Responsibilities

I agree to:

- Fully disclose if I am/my child is unwell in the lead up to or on the day of an appointment. Please contact Signal Health to cancel the appointment with as much notice as possible. This gives you or your child the opportunity to rest and recover and reduces the risk of spreading the infection as your dietitian may see clients who may be immune suppressed.
- Fully disclose any medical conditions, medications, allergies, and supplements that I am/ my child is taking, including any changes to medications or dosages during the treatment period, as these may affect my/ my child's treatment plan.

Understanding of Treatment & Risks

I acknowledge that:

- The Dietitian is not a medical doctor and does not replace conventional medical care.
- Nutrition advice may have potential risks and benefits, including but not limited to:
    - **Risks**: temporary aggravation of symptoms, feed intolerance during trial periods of feed changes, or other individual responses.

    - **Benefits**: symptom relief, improved overall health, nutritional balance and/or recovery, and chronic disease prevention.
- I will contact my Dietitian or my GP/ Paediatrician immediately if my child experiences any adverse reactions.
- I do not expect guarantees of specific outcomes, as treatment responses vary.

Ongoing Informed Consent

I understand that:

- This informed consent and service agreement is an ongoing agreement, and additional consent may be required if there are significant changes to my treatment plan.
- If treatment methods change, my ongoing verbal or written consent may be recorded in my consultation notes rather than requiring a new signature.

AI generated notes and assistive tools.

I understand that:

- The Dietitian may use artificial intelligence (AI) tools, such as Lyrebird, Heidi or similar, to assist in capturing and summarising consultation notes.
- AI-generated notes are used as an internal support tool and do not replace professional judgment or clinical assessment.
- If I prefer not to have AI tools used, I must notify the Practitioner before my consultation.
- My personal information, including AI-generated notes, will be handled in accordance with Australian privacy laws and the clinic's Privacy Policy

Privacy & Data Handling

By signing this document, I consent to the collection, use, and storage of my personal information for treatment purposes. My information will be handled in compliance with Australian Privacy Laws and the clinic's Privacy Policy (https://blossomfamilydietetics.com.au/wp-content/uploads/2025/07/Blossom_Privacy_Policy_AUS.pdf).

I understand that:

- My data is not shared with third parties except where required by law or with my explicit consent.
- My notes are stored securely as part of my consultation record.
- I may request access to my records and withdraw my consent at any time.

Acknowledgment & Consent

I confirm that:

- I have read and understood this agreement.
- I have had the opportunity to ask questions about its contents.
- I consent to treatment and understand I may withdraw my consent at any time by notifying my Dietitian.

Name: _____

Signature: _____ **Date:** _____ /_____ /_____

Please complete the following if you are a new patient to Signal Health

Additional Patient Details

Birth sex (required for Medicare)* ◯ Female ◯ Male ◯ Other

Address* _____

Suburb* _____ **Post code*** _____ **State*** _____

What is your country of birth? _____

Do you identify as Aboriginal or Torres Strait Islander?*

◯ Aboriginal ◯ Torres Strait Islander ◯ Both ◯ No

Emergency Contact

First name* _____ **Last name*** _____

Contact number* _____ **Relationship to you*** _____

Next of Kin

◯ **Tick if same as Emergency Contact or complete below**

First name _____ **Last name** _____

Contact number _____ **Relationship to you** _____

Card Details

Do you have a Medicare Card?* ◯ Yes ◯ No *If yes, please provide your details:*

Card number* _____ **Reference No.*** _____ **Expiry date*** ____ / ____

Do you have a Concession Card? ◯ Yes ◯ No *If yes, please provide your details:*

Card Type: ◯ Aged Pension Card ◯ Health Care Card ◯ Disability Pension Card

◯ Carer Pension Card ◯ Newstart

Card number _____ **Expiry date** ____ / ____

Do you have a DVA Card? ◯ Yes ◯ No *If yes, please provide your details:*

Card number _____ **Expiry date** ____ / ____

Account Details

Will you be managing your own accounts with us?*

◯ Yes ◯ No *If no, please provide the name and contact details of the person responsible for managing your accounts below:*

First name* _____ **Last name*** _____

Preferred name _____ **Date of birth*** _____ /_____ /_____

Address* _____

Medicare Card number* _____ **Reference No.*** _____ **Expiry date*** ____ / ____

Contact number _____ **Relationship to you** _____

Communication Consent

Your practitioner or our team at Signal Health Tusmore may contact you via SMS and/or email with important healthcare information, including:

- Appointment reminders
- Clinical information (e.g., test results or follow-up instructions)
- Health reminders from your practitioner (e.g., routine screenings)

If you choose to opt out of these communications, you will not receive appointment reminders, test result notifications, or health reminders from your doctor or our team via SMS or email.

You can update or revoke your consent at any time by notifying our admin team.

I consent to receiving SMS reminders, messages, and emails as described above* ◯ Yes ◯ No

Would you like us to register your provided email for our Signal Health Tusmore website to receive emails about our practice news and updates?* ◯ Yes ◯ No

---

Authorised Contact/s for Clinical Information

We are committed to protecting the confidentiality and privacy of your personal health information. In accordance with our privacy policies and relevant regulations, we will only disclose your clinical information directly to you or to another healthcare provider who is involved in your care (such as a specialist to whom you have been referred).

If you would like to authorise a specific family member or contact person to receive and discuss your clinical information on your behalf - including appointment details, pathology, radiology, or other test results - please authorise the below. Please note that if you don't provide this authorisation, we will be unable to share your personal health information with anyone else, including family members or friends, unless we receive your consent later.

Would you like to authorise a family member or contact person to discuss your clinical information?*

◯ Yes ◯ No *If yes, please provide details below (you can fill out 1 or 2 authorised contacts):*

Authorised Contact 1: Name _____

Contact number _____ **Relationship to you** _____

Authorised Contact 2: Name _____

Contact number _____ **Relationship to you** _____