



# Practice Incentives Program Indigenous Health Incentive and Pharmaceutical Benefits Scheme Co-payment Measure Patient Consent

## Important information

Complete this form if you are of Aboriginal and/or Torres Strait Islander origin and would like your doctor to provide better management of your chronic disease through the Practice Incentives Program (PIP) Indigenous Health Incentive and/or the Pharmaceutical Benefits Scheme (PBS) Co-payment Measure.

## Assistance

If you need assistance completing this form call **1800 222 032** (call charges may apply) between 8.30 am and 5.00 pm ACST, Monday to Friday.

## Lodgement

Give the completed form to your doctor or a member of the practice staff. This form will be kept on file at the practice.

Print in **BLOCK LETTERS**

Tick where applicable

## Your details

**1** Are you of Aboriginal and/or Torres Strait Islander origin? (tick all that apply)

No  You are not eligible

Yes – Aboriginal

Yes – Torres Strait Islander

**2** Dr  Mr  Mrs  Miss  Ms  Other

Family name

First given name

**3** Your sex

Male

Female

**4** Date of Birth

 /  / 

**5** Medicare card number

 -  - 

Ref no.

## Patient consent

**6** Practice name

**7** Practice address

  
 -----  


**8** I want the practice written on this form to be my usual care provider and look after my chronic disease.

No

Yes

**9** I have been told how participation in the PIP Indigenous Health Incentive will help my practice provide better care for my chronic disease. I understand what I have been told, and I want this practice to register me for this program.

No

Yes

**10** I have been told how participation in the PBS Co-payment Measure will make my PBS medicines cheaper. I understand what I have been told, and I want this practice to register me for this program.

No

Yes

## Declaration

**11** I acknowledge that:

- my personal details on this form will be shared between this practice, Medicare Australia and the Department of Health and Ageing for the purposes of running the PIP Indigenous Health Incentive and/or the PBS Co-payment Measure.
- I understand that general participation information (which is not linked to my name or other personal details) will be used to see how well the program is working and help improve services for Aboriginal and Torres Strait Islander people.
- I can withdraw my consent to participate in the PIP Indigenous Health Incentive and/or the PBS Co-payment Measure at any time.

**I declare that:**

- the information on this form is correct.

Patient or parent/guardian's full name

Signature

Date

 /  / 

## Privacy note

The information on this form will be used to register your details for participation in the PIP Indigenous Health Incentive and/or PBS Co-payment Measure. The collection of this information is authorised by the *Medicare Australia Act 1973*. Information on this form may be disclosed to the Department of Health and Ageing, other relevant agencies or as authorised or required by law.