



**MEDICAL**  
Administration Training



# MEDICAL RECORDS

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*from the perspective of a Medical Receptionist*



# MEDICAL RECORDS

Information about an individual's physical or mental health and wellbeing is both personal and sensitive, and there are many ethical, professional and legal restrictions on the way this information can be used.

All workers, regardless of their field or profession, operate within a legal and ethical framework of some kind. This simply means that we all work within the boundaries defined by applicable laws and ethical standards.

An **ethical** framework refers to the system of principles, rules or standards by which human actions are judged right or wrong.

A **legislative** framework refers to the Legislative Acts, Regulations, Rules and directions that govern an industry and/or organisation.

**Legal** standards are based on written **law**, while **ethical** standards are based on human rights and wrongs.

Doctors and medical staff have a strict ethical and legal duty to their patients and the handling and storage of health and medical records. These duties survive a patient's death.

## CONFIDENTIALITY AND PRIVACY

Working in a medical environment involves handling large amounts of sensitive and personal information. Confidentiality is the protection of personal information and in a medical setting means keeping a patient's information between the health professional, administrative staff and the patient, and not releasing this information to anyone without the consent of the patient. In most cases this consent must be in writing.

You are dealing with highly confidential personal information and situations and you should **NEVER** discuss a patient's treatment outside the confines of the medical practice. No information concerning a patient may be given out without the direct authorisation of a practice doctor and without written consent of the patient.

The Privacy Act is a legal framework designed to protect the privacy of personal and health information. This means there are added restrictions on how health service providers can handle health information compared to other types of personal information.

Patients of a medical practice need to know their information is kept private and confidential. It is important that all patients understand the practice privacy policy and new patient's registration forms include a statement that patients sign to say they agree with the practice privacy policy.

Information collected in the medical sector is often highly sensitive and organisations must adopt the highest privacy compliance standards to ensure that patient's personal information is protected.

In a medical practice the medical staff and practice management are responsible for managing the implementation of established medical record processes.

The role of the medical receptionist is to provide assistance and perform the various tasks required to set up and maintain the record.

It is therefore essential reception staff are familiar with their obligations concerning the confidentiality and privacy of patient medical records. The Australian Privacy principles (APP) set the minimum standard for privacy that organisations must meet.

The Privacy Act includes thirteen Australian Privacy Principles (APPs)

- ➔ APP 1 – open and transparent management of personal information
- ➔ APP 2 – anonymity and pseudonymity



- ➔ APP 3 – collection of solicited personal information
- ➔ APP 4 – dealing with unsolicited personal information
- ➔ APP 5 – notification of the collection of personal information
- ➔ APP 6 – use and disclosure of personal information
- ➔ APP 7 – direct marketing
- ➔ APP 8 – cross-border disclosures
- ➔ APP 9 – adoption, use or disclosure of government related identifiers
- ➔ APP 10 – quality of personal information
- ➔ APP 11 – security of personal information
- ➔ APP 12 – access to personal information
- ➔ APP 13 – correction of personal information

Here are some ways to ensure privacy and confidentiality in the practice:

- ➔ The practice privacy policy must be made available to patients. There is a number of ways of doing this including a sign at reception, a brochure, including it on the new patient registration form
- ➔ Never discuss a patient's medical history with anyone
- ➔ Voices should be kept low at all times throughout the medical practice
- ➔ Never give medical records or reports to anyone including the patient without the doctor's consent
- ➔ Make sure computer screens are not able to be seen by patients standing at the reception desk
- ➔ Files should not be left on the reception counter or be able to be seen if they are on the desk.
- ➔ Be careful of the notes you enter on the system use only professional language not your thoughts.
- ➔ Be careful what, to whom and where you discuss patient's personal information
- ➔ Always verifying a patient's identity



## PATIENT IDENTIFICATION

Verifying a patient's identity helps to maintain patient safety and confidentiality. Failure to correctly identify a patient can have serious, potentially life-threatening consequences for the patient.

Using three approved patient identifiers reduces the risk of misidentifying patients and ensures that practitioners have the correct patient health record for each consultation.

Correct patient identification is necessary when:

- A patient makes an appointment
- A patient presents to the practice for their appointment
- You communicate with a patient over the telephone or electronically
- A patient telephones asking for a repeat of a prescription
- A patient sees more than one practitioner during a visit
- A patient record is accessed
- You collect and manage information (e.g. scanned documents, X-rays) about a patient.

Approved patient identifiers are items of information that are accepted for use to identify a patient. They include the following patient details:

- Name (family and given names together are one identifier)
- Date of birth
- Gender (as identified by the patient)
- Address
- Patient health record number where it exists
- Individual Healthcare Identifier

**Note:** A patient's Medicare number is not an approved patient identifier, as some Australian residents and visitors do not have a Medicare number and others may share numbers if they belong to the same family.



# MEDICAL RECORD *legislation*

Medical records should comply with any relevant legislation for record keeping. It is important to note that legislation may vary from state to state.

Most practices will provide you with a position descriptions and statements of responsibility, which should explicitly define the medical receptionist's obligation to protect patient privacy and confidentiality and the consequences of intentional breach of the obligation.

There may also be policies, procedures and protocols addressing standards and processes for managing healthcare information. In maintaining patient files you must adhere to your employer's policies and procedures, and strictly abide by the Australian Privacy Principles.

## What is a medical record?

A 'medical record' is a general term for all of the information collated about a patient for the purpose of treating that patient, including:

- Progress notes - handwritten or computerised
- Specialists' letters and other correspondence
- Test results
- X-rays and scans
- Photographs
- Digital recordings
- Appointment books and patient accounts

Medical records should include the following information:

- Patient identification (personal information)
- Information relevant to diagnosis or treatment
- Treatment plan
- Medication and dosage levels
- Information and advice given, consent discussions
- Details of any medical or surgical procedure (date, nature, who performed procedure, type of anaesthetic, tissues sent to pathology, results or findings, written consent)
- Health summary that is easily accessible, including significant history, medications, allergies

Medical records traditionally were kept in paper form, with tabs separating the sections. As printed reports were generated, they were moved to the correct tab. With the advent of the electronic patient record, these sections may still be found but as tabs or menus within the electronic record.



# My Health Record

## E-Health Records

Since July 2012, Australians have had the option of registering for a personally controlled electronic health record (PCEHR). This patient-controlled record is kept completely separate from the patient's electronic medical record. The fact that a patient may have a PCEHR does not alter the doctor's obligation to maintain a medical record for the patient.

## Who owns the Medical Record?

In a private medical practice, the ownership of the medical records depends on the structure of the practice. Generally medical records are owned and controlled by the medical practice attended by the patient.

## Access to and transfer of Health Records

Access to health records and financial/accounts information by the patient/relative, legal representative or other medical practitioners should comply with privacy legislation.

Patients, have a general right of access to information held about them and should ideally provide a written request for access to their records or to request a transfer of their records. A copy of the request should be kept in the patient's medical record.

If a patient wishes to transfer to another doctor, the new practitioner is entitled to a treatment summary or a copy of

the records. The transfer date and location of transferred records should be maintained in a register, and the transfer date added to record.

If it is necessary to transport a health record to another destination it is essential that staff understand how and what method of transportation must be used to ensure availability, maintain the security and reduce the risk of the loss of the health records.

It is likely now days that the practice may have an Electronic Health Record system so in some instances may be able to transfer and encrypted file of the health record

Some practices may charge for providing copies of medical records.

## How should Medical Records be stored?

Medical records may be kept in paper or electronic format, or a combination of both. Where a 'hybrid' of paper and electronic records is used, a system is required to cross reference the records for each patient. Electronic records need to be kept in a form that allows them to be printed out as required.

Medical records should be kept secure. They should be stored out of public view and access at all times. Staff should not disclose their contents to anyone other than authorised personnel.

## Medical Records Tracker

Tracing hard copy medical records in larger practices can be challenging. To keep tabs on where files are in this circumstance, many large practices insert a Medical Record Tracer card to replace the medical record that has been removed to ensure the file can be found if needed.

## How long are records kept?

Medical records should be retained for as long as required by relevant Australian, state or territory government legislation.

If a patient has become inactive their file is not destroyed. It is archived at a secure facility for a specified period of time before it can be destroyed. This time is normally between 7-15 years depending on the State or Territory. Some records may need to be kept for a longer period of time. Some examples of these are as follows:

- If the patient is a minor then they need to be kept for seven years after a patient's 18<sup>th</sup> birthday
- Genetics (Permanent Retention)
- Implants and Artificial Devices (Permanent Retention)
- Organ and Tissue Transplantation (Permanent Retention)
- Indigenous health care (Permanent Retention)
- Blood and Blood product transfusion (Permanent Retention)
- Obstetrics (Up to 33 years after last contact)

## Disposal of paper-based medical records

Disposing of paper copies of documents and notes that have been transferred or scanned into the electronic records is allowed as long as the disposal is done in a manner which preserves confidentiality and complies with legislative requirements. In New South Wales, a register of all records that have been destroyed should be kept. Whilst this is not a requirement in other states, it would be considered good practice to keep a record in other states as well. Before you destroy records you must have authorisation to do so.

## Methods of Destruction

The destruction of records must be done securely. The practice may have policies and procedures as part of the record keeping system.

Choose a method suitable for the document's sensitivity is critical e.g. use cross shredding in a 2 axis **shredder** for sensitive documents or a **commercial destruction service** - the service contract should require that records are securely transported and destroyed as soon as possible after their arrival at the destruction site.

## Keeping medical records secure

With the increased use of information technology in health care, medical clinics must take reasonable steps to protect the information from loss and unauthorised use or disclosure.

To ensure that electronic records are kept safe from damage, loss or theft the below is suggested:

- Promote a security culture within the practice
- Control who has access to the organisations and clinical information.
- Set up staff access levels for different staff members (e.g. it is unlikely the receptionist is going to need access the patient health information)
- Ensure strong access passwords protection is in use
- Ensure the practice is using up to date, compliant practice software
- Utilise encryption controls to protect transmitted data over a network
- A complete backup of the computer record should be performed on a regular basis. Ensure the backup is stored as per Australian privacy regulations
- Computers should be password protected and the passwords changed on a regular basis
- Use of firewalls will protect computer systems against unauthorised access and computer viruses
- Staff should be fully trained in systems and protocols



## Patient Consent

Health information is any information about a person's health or a disability, as well as any other personal information collected while they are receiving a health service.

Generally, a provider can only collect a patient's health information when the patient consents to them doing so, and the information is reasonably necessary for them to carry out their functions or activities (such as diagnosing or treating an illness).

When a provider requires a patient's consent to collect their health information for a particular purpose, they generally should ensure the patient understands what will happen to the information and what they are consenting to.

A patient must provide their consent for the collection, use or disclosure of their personal health information. A patient's consent can be either implied or express.

**Implied consent** is not given by a patient in writing, but is understood from the circumstances surrounding their medical care. It is consent that is inferred from actions, or facts, or even by inaction or silence. For example raising your arm when your doctor takes your blood pressure.

**Express consent** is permission for something that is given specifically (usually in writing). If express consent is in writing, it should include the doctor's details, any authorised treatment (or details the patient's consent to their records being released to a third party) and the date.

In most situations, the signing of a consent form that includes all of this information evidences express consent.

The patient's consent should be given voluntarily. They also need to have the capacity to consent to their health information being collected.

In some circumstances, it may be impossible to obtain valid consent. For example if the patient is unconscious.

Sometimes the patient will give permission for someone else to manage their medical record. Health related matters are covered by advanced care planning legislation and differs in each State of Australia.

### Express consent example

If a patient wants their records transferred to another Doctor they must give written or express consent. Likewise if another party such as an employer, insurance company etc. requires personal or health information it is necessary for the patient to provide written and signed consent before information can be released.

### Implied consent example

There may be times where the consent to a provider collecting the health information can be implied. For example, a Doctor would not normally need to specifically ask you for permission to make notes of symptoms you describe during a visit because your consent can be implied from your attendance of the appointment and describing your symptoms.



## HEALTH INFORMATION MANAGEMENT

Health information management is the process of maintaining, storing and retrieving patient health information in accordance with applicable Federal, State, and accrediting agencies' requirements.

Maintaining patient records involves various tasks and responsibilities which may include:

- Filing and retrieving patient records
- Updating information in the patient record
- Ensuring records are labelled and orderly
- Correctly archiving records for inactive patients
- Transferring patient records

Maintaining the medical records for patients includes ensuring the accuracy and accessibility of the records for continuity of care throughout the lifetime of the patient. These include both paper and electronic medical records.

Checking records are up-to-date is very important. Many medical practices will check details such as address, contact phone numbers, emergency contacts, expiry date for Medicare cards and insurance details for currency.

## FILING

Medical records filing include designing and developing the structure of the health information management system that is easily accessible, organised and protects patient confidentiality.

Types of filing methods used for filing medical records are:

- ➔ **Alphabetical** – an alphabetical system places files in alphabetical order according to the patient's family or last name.
- ➔ **Chronological** – Chronological filing is used in conjunction with other filing methods and involves sorting records according to their date in a patient file. For example, correspondence would be filed with the most recent date on top.
- ➔ **Numerical** – Each file or piece of information is filed in number order, from lowest to highest according to:
  - a. The number on the document
  - b. The patient number or account number
  - c. Some practices may have their own number system.

Numerical systems are usually an indirect method of filing and need to be cross-referenced to an alphabetical index, for example, an alphabetical list of patient names showing their identification number. Alphanumeric systems combine both letters and numbers in a file reference.

- ➔ **Colour coding** – A colour coding filing system uses a combination of colours and letters and/or numbers which create a pattern that makes files easier to locate and significantly minimises misfiling, as a file that has been filed incorrectly will break the pattern. In colour coded filing systems, a colour is allocated to each letter or number; for example, red for J, blue for B, green for C, and black for E etc. File folders with coloured tabs and printed letters can be created by medical practice staff or purchased commercially.

**Note:** Pathology results, diagnostic imaging reports and clinical correspondence should be reviewed by a doctor prior to filing.



# ACCESSING PATIENT *records*

As a medical receptionist it will be your responsibility to access and maintain a patient's file. Your role within the medical practice will determine what access you may have to certain patient records.

Today accessing patient's files is very easy as a lot of practices are computerised. When a practice is computerised the doctors will access a patient's clinical notes themselves as these are all stored within the computer software.

To find a patient's details on the computer all you need to do is type their surname into the system and the computer will automatically find the patient's matching that name. You then select the patient you require. When a practice is computerised the entire patient's data is electronically stored, including pathology or x-ray results.

If a practice is not computerised then it will be up to the receptionist to find the patient's file for the doctor and to file it away once the doctor has finished with it.

## UPDATING PATIENT DETAILS

It is essential that patient details are kept up to date. After all you do want to be able to contact the patient should you need to. Many practices have procedures that require the receptionist to check patient's details are current either when the patient phones to book the appointment or when they attend the practice. Patients may be asked to confirm their address, contact phone numbers, emergency contacts etc. Medicare card currency and health insurance details may also be confirmed.

Patients may get annoyed with the questioning so it is best to explain the importance for up to date details.

## ARCHIVING PATIENT MEDICAL FILES

Copies of medical records must never find their way into the general waste from the office. When printing, if errors are made, the paperwork must be destroyed appropriately. This may include copies of banking records, receipts, patient records, or any other form of record that may be kept.

Paper must be shredded, or destroyed by a classified waste contractor (such businesses are licensed and accredited for this purpose).

Archiving of records will be carried out when a patient has become inactive at your practice. Reasons for this may be:

- The patient has moved away
- The patient has not visited your practice within the last 2 years
- Death of a patient

## DISCLOSURE OF INFORMATION

Disclosure of information refers to the release of patient information to a third party organisation/person outside of the practice. There are strict guidelines on the release of patients' personal information, including their medical records.

Sources of information disclosure requests may come from other health professionals, insurance companies and government agencies.

Why might patient information be disclosed?

Other than exceptional circumstances permitted or required by law, medical records should not, without the patient's express up-to-date written consent, be disclosed to persons other than the patient unless the patient would reasonably expect such disclosure to take place, in accordance with relevant privacy legislation. For example, it is likely a patient who has consented to the collection of their personal information for their health care may reasonably expect the doctor to share the patient's medical record amongst the treating health care team.

An individual that has been appointed as a medical treatment decision maker will have the right to access the medical records.

## GOVERNMENT REPORTING

Doctors must report certain diseases they've treated over a certain time period so that the government can monitor the nation's health – these are referred to as notifiable diseases. Doctors can also use health information if necessary to protect public health, such as reporting a flu outbreak.

Doctors must also report suspected cases of child abuse, even when the child or parent don't expressly authorise the disclosure. Similarly, if a doctor thinks their patient's mental state will cause them to be a danger to themselves or others, they may report this in order to prevent harm to others.

## PERSONAL INJURY OR WORKERS' COMPENSATION CLAIM

If the patient has lodged a personal injury or workers' compensation claim, in which his/her health is a major issue, the doctor may need to provide medical records, a written or verbal report, or attend court and testify about the patient's injuries.

# RELEASE OF PATIENT *records*

Patient information may be requested for numerous reasons such as insurance purposes or continuity of care. The Practice has the responsibility to release information in a timely manner upon proper authorisation of the patient or their authorised representative.

Release of information services include:

- Obtaining valid authorization for release of protected health information
- Completion of the medical record for copying
- Transmitting of the electronic health record
- Tracking requests and monitoring the timeliness of the response

## PATIENT FOLLOW UP ACTION

The practice is required to have a 'Follow up system' to ensure that:

- all received test results and clinical correspondence (e.g. reports from other healthcare providers) relating to a patient's clinical care are reviewed
- clinically significant tests and results are followed up
- patients are made aware of the seriousness of not attending for follow up
- patients' are made aware of who is responsible for communicating with whom about results and when this is to occur.

In addition to the follow up system the practitioner may also communicate specific required follow up actions to you verbally, noted on the patients file or electronically. As an example: the doctor may need to see the patient in two weeks to review their progress so has noted on the patient file for you to schedule another appointment.

When working in the health administration field one of the most common tasks you will perform will be either to enter

A new patient will be required to fill-out and sign a patient registration form.

Information required to create a patient record includes but is not limited to:

- Patient's name, address, phone and email contact details
- Sex, Age, Birthday, and Race (Ethnicity)
- In case of emergency contact information
- Medicare number
- Private Health insurance information
- Concessions, e.g. healthcare card
- Existing medical conditions/known allergies

It is essential that the information you put into the system is accurate as this forms the basis for the patient's visit. If you are working in a computerised practice, you enter all the patient's details in the 'create new patient' section of the program. The computer will then generate every component of the file it needs from this one entry.

You may be required to make a small paper file which will hold all patient's correspondence e.g. registration form, medical reports, pathology results etc. If you are working with a manual system it will depend on your practice policy and procedures as well as relevant regulations as to how these files will be constructed.

If your system is fully computerised all registration forms, referral letters etc. will be scanned into the patients computerised file.

All details of rebates and entitlements patients receive will be built into the software system for ease when processing accounts as well as acting as a database for all patient information.

There is an assortment of programs out there and they are all very similar in their operation. For the purpose of our training we use Pracsoft or Best Practice as they are the most commonly used medical programs in Australia wide.

# Examples of medical records used by medical *administrators*

## NEW PATIENT REGISTRATION

Following is an example of a patient registration form. This can be used whenever a patient has changed their details and should always be used when you have a new patient arrive at the practice.

## Patient registration form



Please take your time to provide the following information as accurately as possible.		TODAY'S DATE:					
				MM	DD	YY	
<b>MY PERSONAL DETAILS</b>							
SURNAME		TITLE Mr / Mrs / Ms / Miss / Dr					
GIVEN NAME		PREFERRED NAME					
DATE OF BIRTH		OCCUPATION					
HOME ADDRESS		SUBURB			POSTCODE		
EMAIL		HOME PHONE			MOBILE		
Private Health Insurance with							
Private Health Member No		DVA No					
Pension / Healthcare Card No							
<b>My Medical History</b> Please indicate if you have or ever have had any of the following							
		Yes	No			Yes	No
High blood pressure				Diabetes			
Heart problems, defects or pacemaker				Thyroid problems			
Rheumatic fever				Excessive bleeding or blood disorder			
Asthma, chest or breathing problems				Epilepsy			
Tuberculosis				Hepatitis			
Stomach or bowel problems or ulcers				AIDS / HIV			
Kidney disease				Cancer			
Anxiety or depression				Any other contagious disease			
Do you have any heart valve, hip or other orthotic implant?							
Do you have any allergies?							
Please list any medications you are presently taking							
Is there any other medical condition that you wish to discuss in private?							
Is there anything else that I can assist you with?							
<b>How will you be paying your fee?</b>							
<input type="checkbox"/> Cash		<input type="checkbox"/> Cheque		<input type="checkbox"/> Eftpos		<input type="checkbox"/> Health Fund	
						<input type="checkbox"/> Credit Card	
Once complete, please return to the reception desk.							

A referral from a general practitioner (GP) to a specialist lasts 12 months, unless noted otherwise. The referral starts from the date the specialist first attends the patient, not the date issued.

Medical specialists generally don't see patients without current referrals, and being a previous patient of a medical specialist doesn't necessarily mean you can make ongoing appointments, either.

A referral is a letter from a General Practitioner addressed to a particular type of medical specialist. The referral letter will explain the medical reason why the patient is being referred, and may also include any relevant medical history, including allergies and medications.

A referral is necessary to make sure Medicare Benefits are paid at specialist or consultant referred rates, rather than at un-referred rates. In other words, patients do not need a referral to see a specialist, but they do need one to attract the relevant Medicare rebate.

### NO REFERRAL - NO REBATE

The Health Insurance Act of 1973 requires a letter of referral for a patient to see a specialist. A referral letter is generally written by a patient's general practitioner. In order for a patient to obtain a rebate from Medicare, an account detailing the referral must be produced. If a patient attends a specialist and does not have a current referral or has a referral dated after the appointment date with the specialist, then there is no rebate.

Referral letters must be filed in the patient's file (paper or computer file). At any time should Medicare conduct an audit of the practice, they will require a number of files be produced and appropriate referrals found on the file. Each practice will have a set of policies and procedures for the maintenance of records. All files have to be maintained for at least seven years (including the referral letters as part of the files).

A referral letter will state:

- The referring doctor
- The referring doctor's name, practice and contact details including address and Provider Number.
- The name of doctor to whom the patient is being referred.
- The date of writing the referral.
- The length of the referral.
- The reason for the referral.
- Previous medical history.
- Relevant tests, X-rays etc.
- The name, address and date of birth of the patient being referred.

A referral from a general practitioner to a specialist is valid for twelve months, unless otherwise stated. When a patient is referred from one specialist to another, the referral can only be for a three-month period. If the patient has a chronic ongoing condition that will require treatment by a specialist for a very long period of time (maybe a life time) then the referral can be for an indefinite period of time. This is marked as an indefinite referral. This will ensure a patient will keep receiving their Medicare rebate.

Referrals become active on **the first (initial) consultation with the specialist**. This will be the date that is included on all accounts.

If a patient has been seeing a specialist for some time, and is required to see the same specialist but for a new condition, then a new referral is required. The specialist is entitled to treat this patient as a new patient for billing purposes, regardless of how long or frequently the doctor has seen the patient in the past



Dr John Jones  
Good Health Medical Clinic  
6 Firhill Road  
GREENFIELDS QLD 4207  
Ph No. 345 6 321  
Provider no: 6435A

6 August, 2015

Dr Jean Smith  
34 Samvale Rd  
JIMBOOR QLD 4444

**Re: Heather Simpson DOB 10.3.1965**  
**10 Tank Rd**  
**JIMBOOR QLD 4444**

Dear Dr Smith,

Thank you for seeing Heather for review.

She has been suffering from shortness of breath for some four weeks. She has arranged to have a CT of her chest and she will bring this to the consultation.

Her past history includes asthma as a child, but she is currently on no medications.

I would be grateful for your urgent review, and advice regarding continuing management.

Yours sincerely

Dr John Jones

## Invoice

As with any service rendered, an account (also referred to as Invoice) should be generated in order for the patient to pay their bill and receive any Medicare rebate that applies (if they are not bulk billed).

Regardless of how your employer chooses to operate their account service, the information you will be handling is highly sensitive. The rulings under the Privacy Act regarding this information states it be treated in the same way as you would patient notes, test results, x-rays, scans etc. and should not be disclosed to any other person but the patient.

A private patient account should include the following details:

- Doctor's Name
- Qualifications
- Address
- Provider No.
- Patient's Name
- Debtor's Name (may not be the same as the patient name – a child)
- Date of Service
- Item Number for Service
- Description of Service
- Name of hospital at which service was provided (if in hospital treatment).
- In Hospital (\*) or Rooms
- \*\*Time of Consultation (if necessary – more than one consultation in one day) \*\*
- Fee
- Total Outstanding.

\*\*If the account is from a specialist doctor then it will also include the referring doctor's details as well as the date of the first consultation with the specialist\*\*

**Example Invoice follows**

# TAX INVOICE

Dr Charles Powden **MBBS.FRACP**  
Provider No: 034565A  
Suite 32  
Jackson Building  
56 James Street  
BRISBANE Qld 4000  
Ph: 3446 2346



Ms Jill Jones  
6 Cross Road  
WEALERS HILLS Qld 4312

Patient Name: Jill Jones

15 Nov 2018	Item 105	Subsequent Consultation	\$85.00
		Total	\$85.00
		Amount Paid	\$0.00
		Balance Outstanding	\$85.00

**DATE                      ITEM NO.                      DESCRIPTION                      FEE/AMOUNT**

Referral: Dr J Green  
6 James St  
BRISBANE QLD 4000  
Provider No: 012345  
7<sup>th</sup> Nov 2018

## Receipt

A receipt is issued once the account has been paid. In the medical environment it is very important that the receipt be accurate, as a rebate may be available from Medicare, and sometimes the patient's private health insurance.

The receipt should contain the following details.

- Date of receipt
- All the billing details from the account they are paying
- The portion of the account that has been paid (i.e. the Medicare rebate, the patient gap or the total amount outstanding)
- Doctor's name, or practice name, address, telephone number
- Provider Number
- Patient's name
- Debtor's name (if different to patient)
- Type of payment (i.e. Cash, cheque, Medicare, Private Health Insurance, Credit Card, EFTPOS, money order, bank cheque)
- The final amount outstanding.

**\*\*If the receipt is from a specialist doctor then it will also include the referring doctor's details as well as the date of the first consultation with the specialist\*\***

Often the account and receipt will be produced together. This is very effective, as the patient will need both these items when claiming from Medicare or their health insurance.

**Example Receipt follows.**

Dr Charles Powden **MBBS.FRACP**  
Provider No: 034565A  
Suite 32  
Jackson Building  
56 James Street  
BRISBANE Qld 4000  
Ph: 3446 2346



Ms Jill Jones  
6 Cross Road  
WEALERS HILLS Qld 4312

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**RECEIPT**

Patient Name: Jill Jones

<b>DATE</b>	<b>ITEM NO.</b>	<b>DESCRIPTION</b>	<b>FEE/AMOUNT</b>
15 Nov 2018	Item 105	Subsequent Consultation	\$85.00
		BALANCE	\$85.00

Amount Received

30 Nov 2018 Medicare Cheque No 546783 \$36.55  
30 Nov 2018 Private Cheque No 345 \$48.45  
(NAB Greenwich Branch)

Total Received \$85.00

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**BALANCE OUTSTANDING NIL**

Referral: Dr J Green  
6 James St  
BRISBANE QLD 4000  
Provider No: 012345  
7<sup>th</sup> Nov 2018



#### Disclaimer

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The producers of this material accept no liability or responsibility for the accuracy or completeness of the information contained within or for any loss or damage whatsoever suffered as a result of direct or indirect use or application of any of these training materials.



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**MEDICAL ADMINISTRATION TRAINING**

Ph: 1300 887 082

E: [info@medtrain.com.au](mailto:info@medtrain.com.au)

W: [www.medtrain.com.au](http://www.medtrain.com.au)