

PATIENT INFORMATION FORM AND FINANCIAL CONSENT

PATIENT DETAILS	Please tick: ☐ Mr ☐	☐ Mrs ☐ Ms	☐Miss ☐Ma	aster 🗌	Dr	
Family Name Given Name(s)						
Date of Birth	Ag	e				
Address						
Suburb			Pos	tcode		
Telephone: (Hm)	(N	Лоb)		. (Wk)		
Next of Kin			Telephone			
Location of injury: (plea-	se tick)					
Hand / Upper limb	Lower	limb	Bac	k	Other	
REFERRING DOCTO	OR'S DETAILS					
Referring Doctor .	Referring Doctor Clinic Name:					
GP DETAILS (If not t	he referring doctor)					
Doctor			Telephon	e		
HEALTH INSURANC	E DETAILS					
Do you have Private Health Insurance? YES NO						
Do you have Hospital Cover? YES NO						
Do you have cover for Occupational Therapy/Hand Therapy? YES NO						
Health Fund Membership No						
Medicare Number Position Number Expiry						
Veteran Affairs No Gold or White Card Holder						
Pension Card No						
Please note that Occupational Therapy/Hand Therapy may be an integral part of your treatment and effective recovery so consultations fees or out of pocket expenses may be payable. Initials						
PHOTOGRAPHY						
I acknowledge that photographs may be taken of my injury for training and injury management purposes,						
and that this is in my	best interest.					
Signature			Date			

This signature confirms your consent for us to collect this information from you. The information will be used for administrative, billing and debt collection purposes, and for referrals and requests regarding your healthcare.

It is routine in this surgery for the surgeon to take photos for research and educational purposes. Should your surgeon wish to use your information, they will discuss this with you during your consultation.

SPECIALIST CONSULTATION FEES

		_
Initial Consult	\$ 200.00 (Private Fee)	Medicare Rebate: \$72.75
	\$ 100.00 (Presentation of Pensioner Concession Card)	Medicare rebate not claimable without valid referral
Subsequent Consult	\$100.00 (Private Fee)	Medicare Rebate: \$ 36.55
•	\$ 50.00 (Presentation of Pensioner Concession Card)	Medicare rebate not claimable without valid referral

SURGICAL FEES

OUT-PATIENT PROCEDURE

If your procedure is performed in our Redimed theatre, you will be required to pay a <u>minimum</u> of \$500.00 out of pocket expense the day of surgery. This fee is <u>NOT</u> claimable from Medicare or your Private Health Fund. You will also be required to pay the full amount for your surgical item numbers, which are raised depending on the complexity of your surgery. You will then be able to claim the FULL amount of this portion of your invoicing if you are eligible to claim with Medicare

are eligible to claim with Medicare Overseas Patients are required to pay in full all costs before their surgery.							
PUBLIC LIABILITY All consults at Redimed and 2Hands need to be paid on the day of the consult. It is your responsibility to seek reimbursement from the company or insurer.							
GP CONSULTATION FEES							
Culting and Companity	CCC OO (Driverte Fee)	Madiagra Dahata, 620	20				
Subsequent Consult: Extended Consult:	\$66.00 (Private Fee) \$122.00 (Private Fee)	Medicare Rebate: \$36. Medicare Rebate: \$70.					
NURSE PRACTITIONER CONSULTATION FEES							
Initial Consult:	\$50.00 (Private Fee)	Medicare Rebate: \$33.	.80				
Subsequent Consult:	\$25.00 (Private Fee)	Medicare Rebate: \$17.	85				
HAND THERAPY CONS		NEURO-MUSCULAR C					
Initial Consult: Subsequent Consult:	\$80.00 (Private Fee) \$65.00 (Private Fee)	Initial Consult: Subsequent Consult:	\$90.00 (Private Fee) \$70.00 (Private Fee)				
Subsequent Consuit.	φος.ου (Filvate Fee)	Subsequent Consult.	\$70.00 (Filvate Fee)				
PHYSIO THERAPY COM	ISULTATION FEES						
Initial Consult:	\$85.00 (Private Fee)						
Subsequent Consult:	\$70.00 (Private Fee)						
			our level of ancillary cover. It will				
NOT be covered through	Medicare. Please advise your	therapist if you are uninsure	d.				
	ason your invoice is forwarded	to the debt collector, you wil	Il be liable for all associated				
collection fees.							
Name:	Signature:	Date:					
			and agree with it. The fees have				
also been explained to m	ne and I have also had the oppo	ortunity to ask any questions IN FOR PRIVATE PATIENT:					
Vou are being seen at			nation held by Redimed will be				
			ed to any person without your				
			examination, investigations and				
			your permission to contact your				
			person/organisation please state				
	me of the consultation and sign						
	and the information on my rights						
Name	Cimpotumo	Data					
This signature confirms t	Signature: hat I have read the above state	ement and that I understand	and agree with it.				
I consent / do not consent to the release of medical information and notes to my general practitioner.							
Signature:	Date:						
	do not consent to the	release of medical info	ormation and notes to my				

Doctor: ______ Practice Name: _____ Ph: _____ Fax:_____

I would request and consent for Redimed to release information to my medical condition to:

Signature: _____ Date: ____

Medical Practice Information: