PATIENT INFORMATION FORM AND FINANCIAL CONSENT

Welcome to REDiMED Total Injury Management

Please take your time to answer the following questions as accurately as possible:

PATIENT DETAILS Please tick: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr ☐

Family Name …… Given Name(s) ……..

Date of Birth …… Age ……..

Address ……

Suburb …… Postcode ……

Telephone: (Hm) …… (Mob) …… (Wk) ……

Next of Kin …… Telephone ……

Email *(REDiMED will provide copies of your medical certificates via email)* ……

Medicare number …….. Reference number..…… Expiry_____

INJURY DETAILS

Date of Injury _____ What's Injured (Eg: Wrist/Leg) ……..

Description of Injury (Eg: Fracture/Laceration) ……

How Injury Occurred

Location where Injury occurred ……..

WORKERS CLAIM OR MOTOR VEHICLE ACCIDENT CLAIM DETAILS

(Not all injuries sustained at work will result in the lodgement of an insurance claim)

Company name ……Site……Occupation……

Address of the company you work for ……..

Contact Person/Supervisor name …… Phone ……

Insurance company that your employer uses ……Claim number……

PLEASE NOTE

It is your responsibility to ensure that your workers' compensation claim forms and your first medical certificate have been completed and submitted to your employer so your claim can be processed. *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, he will discuss this with you during consultation.*

Name:_____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.

REFERRING DOCTOR'S DETAILS

Please be advised if you do not bring a valid GP referral and your workers compensation claim is declined, (or your employer does not settle your accounts) you will be unable to claim medical expenses from Medicare. Please ask at reception if you require a GP referral to be done by one of our GPs at Redimed.

Please note: Some of our doctors at Redimed are not Medicare providers, therefore their accounts are not claimable from Medicare, please ask at reception for further details.

BILLING INFORMATION

In order for you to receive treatment at REDiMED you must sign below. If your claim is NOT ACCEPTED by the insurance company, or your accounts are not settled by your employer, you will be liable for any invoices issued during the course of your treatment. If this occurs you may not be able to claim from Medicare.

If your account is forwarded to the debt collector, you will be liable for all fees associated.

Name:_____Signature:_____Date: _____

This signature confirms that I have read the above statement and that I understand and agree with it.

MOTOR VEHICLE CLAIMS

Your consults at Redimed need to be paid on the day unless you can provide written acceptance of liability by Insurance Commission of WA (ICWA).

AUTHORITY FOR THE RELEASE OF INFORMATION

I _____(name) give permission for you to forward confidential information regarding my injury, the treatment I have received and guidelines for return to work to my employer, insurance company and rehabilitation provider.

Name:_____Signature:_____Date: _____

This signature confirms that I have read the above statement and that I understand and agree with it.