Total Health Solutions
REDIMED

# PATIENT INFORMATION FORM AND FINANCIAL CONSENT

**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 ……

Location of injury: *(please tick)*

☐ Hand / Upper limb ☐ Lower limb ☐ Back ☐ Other

## REFERRING DOCTOR'S DETAILS

Referring Doctor …… Clinic Name:……

**GP DETAILS** (If not the referring doctor)

Doctor …… Telephone ……

## HEALTH INSURANCE 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.*

**Explanation of Billing - Informed Financial Consent we request that fees be paid at the time of 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 **minimum** of $500.00 out of pocket expense the day of surgery. This fee is **NOT** 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

**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

| | | |
|---|---|---|
| Subsequent Consult: | $66.00 (Private Fee) | Medicare Rebate: $36.30 |
| Extended Consult: | $122.00 (Private Fee) | Medicare Rebate: $70.30 |

## 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 CONSULTATION FEES**

| | |
|---|---|
| Initial Consult: | $80.00 (Private Fee) |
| Subsequent Consult: | $65.00 (Private Fee) |

**NEURO-MUSCULAR CONSULTATION FEES**

| | |
|---|---|
| Initial Consult: | $90.00 (Private Fee) |
| Subsequent Consult: | $70.00 (Private Fee) |

**PHYSIO THERAPY CONSULTATION FEES**

| | |
|---|---|
| Initial Consult: | $85.00 (Private Fee) |
| Subsequent Consult: | $70.00 (Private Fee) |

*These fees will be covered through private health insurance and dependent on your level of ancillary cover. It will NOT be covered through Medicare. Please advise your therapist if you are uninsured.*

Please Note: If for any reason your invoice is forwarded to the debt collector, you will be liable for all associated collection fees.

Name: _____Signature: _____ Date: _____

*This signature confirms that I have read the above statement and that I understand and agree with it. The fees have also been explained to me and I have also had the opportunity to ask any questions regarding the fee structure.*

## PATIENT INFORMATION FOR PRIVATE PATIENTS

You are being seen at Redimed as a private patient and accordingly any information held by Redimed will be treated as private and confidential. No information will be released by Redimed to any person without your expressed consent. Redimed would routinely want to convey the results of any examination, investigations and treatment to your own personal General Practitioner and accordingly we request your permission to contact your general practitioner. Should you wish Redimed to release information to any other person/organisation please state this to the doctor at the time of the consultation and sign the appropriate consent section.

I have read and understand the information on my rights as a private patient.

Name: _____Signature: _____ Date: _____

*This signature confirms that I have read the above statement 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: _____

- I consent / do not consent to the release of medical information and notes to my employer_____.

  Signature: _____ Date: _____

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

**Medical Practice Information:**

Doctor: _____ Practice Name: _____ Ph: _____Fax:_____