INFORMED FINANCIAL CONSENT

Provider No: 0123456X

Patient copy provided ☐

URN: _____ VOL: _____ ROOM: _____

SURNAME: _____

GIVEN NAMES: _____

GENDER: M ☐ F ☐ X ☐ DATE OF BIRTH: _____

ADDRESS: _____

_____ PCODE: _____

EMAIL: _____

MOBILE: _____ HOME: _____

IMPORTANT INFORMATION: The below estimate is based on information available at the time of completing a health fund eligibility check.

INPATIENTS: Patient may incur additional charges not covered by private health/ third party insurance or Medicare including but not limited to pathology, diagnostic scans, pharmaceuticals and other items not related to your admission. The patient is responsible for payment of these costs and an invoice will be generated at the end of the month.
DAY PATIENTS: Private Health Fund Insurers are strict in the requirement for patients to attend the full group session time requirements. This means that should a patient not attend the full session (e.g. arrive late or leave early by even a few minutes), then the patient will be liable for the full amount of the session. For any out-of-pocket patient costs, an invoice will be generated and due asap.

INSURANCE DETAILS AND HOSPITAL QUOTATION

PRIVATE HEALTH ☐ DVA ☐ WORKCOVER/ THIRD PARTY ☐ SELF INSURED ☐

Insurer: _____ Level of Cover: _____ Membership/ Claim No: _____

Date of Eligibility Check: _____ Admission Date: _____ Anticipated Days: _____

	Patient Cost
Overnight Accommodation	$
Other Costs (see attached)	$
Excess Payment (as per policy with Private Health Insurer)	$
Co-Payment (as per policy with Private Health Insurer)	$

*** The above mentioned patient costs are payable on day of admission, unless specified ***

DECLARATION BY PATIENT OR NOMINEE

I _____ *(the patient or nominee)* named herein undertake to pay the patient cost as indicated together with any unforeseen costs which may arise as a consequence of this hospital stay. I understand it is for a specific time period and acknowledge it is my responsibility to confirm with my health insurance the levels of cover that I have and any amount that will be my responsibility to pay.

SIGNATURE: _____ DATE: _____