**PATIENT INFORMATION FORM AND FINANCIAL CONSENT**

**Welcome to the Practice**

**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 ………………………………

**REFERRING DOCTOR’S DETAILS** (IT IS IMPORTANT TO PROVIDE US WITH THIS INFORMATION TO ENSURE YOU ARE ABLE TO CLAIM MEDICARE REBATE)

Referring Doctor …………………………………… Clinic Name:……………………………………

**YOUR GP DETAILS** (IT IS IMPORTANT TO PROVIDE US WITH THIS INFORMATION SO WE ARE ABLE TO LIASE WITH YOUR GP AND GP CLINIC)

Doctor …………………………………………….. Clinic Name: ……………………………

**HEALTH INSURANCE DETAILS**

Do you have Private Health Insurance? YES / NO (Please circle)

Do you have Hospital Cover? YES / NO (Please circle)

Health Fund ……………………………………… Membership No………………………………

Medicare Number …………………………..… Position Number ………… Expiry ………

Pensioner Concession Card No. ………………………………………….

Veteran Affairs No. ………………………….….… Gold or White Card Holder (Please circle)

**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**

**PUBLIC LIABILITY**

All consults at REDiMED and Hand and Upper Limb need to be paid on the day. It is your responsibility to seek reimbursement from the company or insurer.

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| **HAND THERAPY CONSULTATION FEES**  **MEDICARE BENEFITS SCHEME (previously Enhanced Primary Care)**  Initial Consult: $30 Gap (If over 45 minutes)  Subsequent Consult: $10 Gap  **PRIVATE FEES**  Initial Consult: $80.00 (Private Fee)  Subsequent Consult: $65.00 (Private Fee)  Consumables, E.g. Splints, will be invoiced at private rates; Please discuss with your treating therapist where indicated.  **\*\* Private health funds cannot be applied to cover gap payments for MBS sessions as per the Medicare Guidelines\*\*** |

**MEDICARE BENEFITS SCHEME/ ENHANCED PRIMARY CARE**

I acknowledge that if I am accessing allied health provider sessions through the MBS/EPC program that I am entitled to FIVE sessions across all providers per calendar year. If I have already claimed these, I will be invoiced at private rates.

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

PRINT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_\_\_

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

*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.*