HCF INFORMED FINANCIAL CONSENT - MEDICAL CHARGES

The purpose of this consent form is to advise you, if you elect to be treated as a private patient, of the likely cost of your treatment, the expected amounts to be reimbursed from your Health Fund and Medicare, and any out-of-pocket costs that may result, so that you are aware of them prior to treatment commencing. This form should be completed and provided to you at least one week prior to your treatment.

PATIENT DETAILS

Patient Name ________________ Date of Birth / /

Address ________________

________________ Postcode ________

HCF Membership No. ________________ Medicare No. ________

TREATMENT/SERVICES EXPECTED TO BE GIVEN

Hospital ________________

Date of Admission / / Estimated length of stay days

Description of Service	Provider Name	Number	Estimated Total Charge	Fund Benefit	Medicare Benefit	Patient Payment
		TOTALS	$	$	$	$

PREPARED BY

This consent form has been prepared by

Print Name ________________

Signature ________________ Date of Birth / /

FINANCIAL INTERESTS IN TREATMENTS TO BE GIVEN

The doctor/s providing these treatments advise they have the following financial interests in the services being recommended:

Dr ________________ Interest ________________

Dr ________________ Interest ________________

Dr ________________ Interest ________________

Dr ________________ Interest ________________

OR No interests in any services ☐ Tick box

PATIENT CONSENT

I have been advised of the above costs and financial interests in respect of my proposed treatment. I understand that the patient payments are my responsibility. I acknowledge that these cost estimates may vary as a result of variation in the treatment provided.

Patient Signature ________________ Date of Birth / /