

The purpose of this form is to advise HCF members of the likely charges for treatment, the amounts to be reimbursed by HCF and Medicare and any out-of-pocket costs that may result. Members should be aware of this information prior to commencing treatment and where practical, this form should be completed at least one week prior to admission. A summary statement of hospital charges will be provided to members approximately six weeks after being discharged from hospital.

1. TO BE COMPLETED BY HCF MEMBER	
Patients Name _____	
Address _____	
_____	Postcode _____
Contact Ph No. _____	Date of Birth ____/____/____
Medicare No. _____	
Hospital cover _____	HCF Membership No. _____

2. TO BE COMPLETED BY HOSPITAL	
Name of Hospital _____	
Date of Admission / /	
Estimated length of stay _____	
On behalf of the hospital, this consent process and patient election has been administered by _____	
(PRINT NAME) _____	
Signature _____	Date / /

3. TO BE COMPLETED BY HOSPITAL						
Hospital Services Description of Service	Provider Name	Item Number	Estimated Total Charge A+B+C	HCF Benefit A	Medicare Benefit B	Patient Payment C
Bed Day Fee						
Prosthesis						
Theatre Fee						
Disposables						
Pharmacy						
Physiotherapy						
Other						
These cost estimates may vary as a result of variations in the treatment provided		Totals	\$	\$	\$	\$

4. DECLARATION TO BE SIGNED BY HCF MEMBER	
<ul style="list-style-type: none"> • Patient/Guardian Consent: I have been advised of the above cost estimates in respect of my proposed treatment. I understand that these are cost estimates and may change as a result of variations in the treatment provided. I understand that the patient payments are my responsibility. • I authorise the referring Practitioner or Provider of the services, or any other authorities concerned with my hospitalisation, injury, disease or ailment, or the treatment or diagnosis, to supply all relevant information to HCF, including a copy of this form and clinical and demographic information as outlined in the Hospital Casemix Protocol data set. 	
Patient's/Guardian Signature _____	Date / /