Φ Dr Fiona Nicholson Gastroenterologist & Endoscopist MBBS PhD FRACP

PATIENT INFORMATION DOCUMENT

Title Mr/Mrs/Ms/Miss Name:		**DOB:**
Address:		
Phone (H):	(W):	Mobile:
Occupation:		Male / Female
Medicare No:	**Expiry Date:**	**Reference No: i.e 1 or 2**
Pension (please specify Age, Disability, HCC etc).	Pension No:	Expiry Date:
Department of Veterans Affairs No		
Gold card or specific treatment card:		

Is this a WorkCover or TAC claim? If so, please state insurer and claim number.

Referring Doctor:

Referring Doctor's Address:

Local Doctor (if not referring doctor):

Please list any other doctors you see on a regular basis:

Are you allergic to any medications? If so, please list them.

Next of Kin:

Relationship of Next of Kin: Phone No:

Signed: **Date:**

PRIVACY INFORMATION & CONSENT

This medical practice collects information from you for the primary purpose of providing quality healthcare. We ask you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and are proactive in your health care needs. We may use the information you provide for administrative purposes in running our medical practice, including billing and compliance with Medicare and the Health Insurance Commission requirements. Information may be sent to other practitioners involved in your care. Confidentiality will always be maintained if any information related to your care is used for research or quality assurance purposes.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I have advised.

Signed:.....Date: .....
(Patient or Parent / Guardian of patient).

Φ **Dr Fiona Nicholson** **Gastroenterologist & Endoscopist** MBBS PhD FRACP

INFORMED FINANCIAL CONSENT

Patient Name:……

Name of private health fund…….

Membership Number:……

Do you have private hospital cover with your fund? …….

Have you served all 12 month waiting periods with your private hospital fund? ……..

Hospital Admissions

Costs may include:

- Excess and/ or co-payments
- Prosthetic gaps - surgically implanted prostheses (prosthetic clips) or medical devices
- Services or treatments restricted under your level of cover

Other Service Provider Accounts

In addition to the hospital costs, you may also have out-of-pocket costs for other services, including the difference between the inpatient consultation fees charged and the amounts paid by Medicare and/or your health fund.

Consultation appointments cancelled within 24 hours or failure to attend an appointment will incur a minimum cancellation fee of $80.

Patients requesting Pathology or Prescriptions without consultation will incur $20 fee to be paid at the time
of request.

We recommend that you discuss these costs with your private health fund prior to your admission.

Other services may include:

- Dr Fiona Nicholson Theatre Fees
- Other Specialists including Anaesthetist, Surgical Assistant etc
- Pathology or Radiology (e.g. blood tests, X-Ray etc)
- Pharmacy

I have been advised that there may be out-of-pocket costs associated with my consultation appointments. and/or hospital admission.

I understand that I will be responsible for any
costs not covered by my health fund/insurer/workcover/TAC/medicare/DVA or any other associate institutions

I agree to pay any additional costs associated with my consultation appointments and/ or hospital admission where applicable.

Signed ……

(If signed by person other than patient, please provide name and relationship to patient)

Date ……