

ESTIMATE OF MEDICAL FEES

Dr.

ABN Number

Address:

Phone:

Fax:

PATIENT'S DETAILS

Family Name		Given Names	
Address			Suburb/City
	State	Postcode	Health Fund
Hospital			Admission Date

PROPOSED PROCEDURE DETAILS

these columns are optional

MBS Item No	Description	Fee	Medicare benefit <small>(please confirm)</small>	Health fund benefit <small>(please confirm)</small>	Estimated patient gap

OTHER SERVICES

There may be a need for other services to be provided for this procedure including:

Type of Service <small>Tick if likely to be involved</small>	Estimate of Fee or Charge	Medicare benefit <small>(please confirm)</small>	Health fund benefit <small>(please confirm)</small>	Patient Gap	Contact for fee information <small>(if known)</small>
Anaesthetist <input type="checkbox"/>					
Assistant Surgeon <input type="checkbox"/>					
Pathology <input type="checkbox"/>					
Radiology <input type="checkbox"/>					

As a service to our patients, we provide the above estimate of the likely medical costs you will be required to pay for your upcoming procedure. As with any medical procedure, if unforeseen circumstances should arise during the procedure it may be necessary to arrange additional medical services. If this happens there may be additional costs to you that are not covered by this estimate. Please note that this is an estimate only of the fees charged by this practice.

You will be liable for any costs not covered by Medicare or your health fund.

Unless otherwise stated, it does not cover services provided by other doctors, such as anaesthetics, radiologists, nuclear physicians or pathologists, or other costs associated with your stay in the hospital or day surgery unit, such as accommodation, pharmacy or physiotherapy.

DECLARATION BY PATIENT OR GUARDIAN:

I understand that this is an estimate only and may be subject to variation. I acknowledge that it is my responsibility to confirm with my health insurance fund the level of cover that I have and any amount that it will be my responsibility to pay. I have been advised that other health professionals may be involved in my treatment and I understand that this estimate does not include their fees or charges unless specifically stated otherwise.

Patient or Guardian's signature		Date	
Guardian's full name			