

Informed Financial Consent: Estimate of Medical Fees

This is an estimate of medical fees only. It does not cover costs of medicines (e.g. including those listed on the Pharmaceutical Benefits Scheme (PBS) or not listed on the scheme i.e. non-PBS), drug administration and related costs that may be incurred for certain treatments (e.g. chemotherapy or other medications for cancer), particularly for ongoing treatment that extend over a long period of time.

PATIENT'S DETAILS *To be completed by the patient*

Family name:	First name:
Hospital:	Admission date: / /
Medicare: Yes <input type="checkbox"/> (number):	No <input type="checkbox"/> Health fund: Peoplecare

To be completed with the treating practitioner

MBS Item No	Description	Doctor's Fees	Medicare Benefit	Health fund benefit (estimate)	Estimated patient gap
Total:					

OTHER RELATED SERVICES *(if applicable)*

Type of Service (Tick if likely to be involved)	Estimate of Fee or Charge	Contact for fee information (if known)
Anaesthetist <input type="checkbox"/>		
Assistant Surgeon <input type="checkbox"/>		
Pathology <input type="checkbox"/>		
Imaging <input type="checkbox"/>		
Devices/Implants <input type="checkbox"/>		
Other health professional <input type="checkbox"/>		
Other health professional <input type="checkbox"/>		

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/guardian signature:	Date: / /
Patient/guardian full name:	
Specialist/practice manager signature:	
Specialist/practice manager full name:	