## 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 b	e comple	eted by the	patient						
Family name:				First r	First name:					
Hospital:					Admiss		sion date:	/ /		
Medicare: Yes [ (number):					No 🗌	Health	fund:			
To be co	mpleted with th	e treatin	g practition	er						
MBS Item No				Doctor' Fees		dicare nefit	Health fund benefit (estimate)	Estimated patient go		
			Total:							
OTHER R	RELATED SERVICE	CES (if ap	plicable)							
Type of Service (Tick if likely to be involved)		Estimate of Fee or Charge			Contact for fee information (if known)					
Anaesthetist										
Assistant Surgeon										
Pathology										
Imaging										
Devices/Implants										
Other health professional										
Other health professional										
I understoresponsible that it will involved	ation BY PATIENT C and that this is an olility to confirm wit Il be my responsibi in my treatment a ecifically stated of	estimate on the state of the st	only and may th insurance . I have been	fund the le advised th	evel of coverage of the coverage of the contract of the contra	er that I nealth p	have and any rofessionals ma	y amount ay be		
Patient/guardian signature:							Date: /	/		
Patient/g	guardian full name									
Specialis	t/practice manag	er signatu	re:							
Specialis	t/practice manag	er full nam	ne:							