DR JOHN HALLIDAY
GASTROENTEROLOGIST & HEPATOLOGIST
MBBS (Hons.), FRACP, DPhil (Oxon)

PATIENT REGISTRATION
The Epworth Centre Richmond
Suite 7.6, 32 Erin Street, Richmond VIC 3121
Telephone: 03 9428 9908 Facsimile: 03 9421 3435
W: drjohnhalliday.com.au Provider No: 246586CX

Personal Details: ☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Other _____

Surname: _____ **Given Name:** _____

Date of Birth: _____/_____/_____ Occupation: _____

Address: _____

_____

Post Code: _____ Email: _____

Phone: Home: _____ Work: _____ Mobile: _____

Next of Kin: _____ Relationship: _____ Phone: _____

Claim Details: **Medicare No**: _____ Ref No: ____ Expiry Date: _____

Do you have Private Health Insurance Hospital Cover? Yes No

Fund Name: _____ Membership No: _____

Concession: Age or Disability Pension No: _____ ☐ ☐ _____ Expiry Date: _____

Veteran Affairs Card No: _____ Expiry Date: _____

Health Care Card No: _____ Expiry Date: _____

Fees:

Description	Item	Fee	Pensioner/ Health Care Card	Medicare Rebate
Initial Consultation	110	$310	$220	$130.20
Long (30-45 mins)	132	$400	$320	$227.70
Review Consultation	116	$150	$100	$65.20
After long consult	133	$190	$145	$114.00
Pill Cam		$250		

The Federal Privacy Act of 1998 requires that fully informed voluntary consent be obtained for the collection of health information. Quality medical care requires full knowledge of patient health information by all members of a medical team. For this reason, your information may be shared with other health providers. Some information may also be provided to Medicare and Private Health Funds for billing and rebate purposes. Health information may be used for 'secondary purposes' such as auditing clinical results and clinical research etc. These activities are a normal part of good medical practice. The privacy of the individual patient is strictly maintained when reporting results of audits or research.

I have read and understood the statement above and give permission for my medical records to be accessed by Dr Halliday or his representative in his practice. I further give my permission for my records to be used for the purposes of audit and research with the understanding that I would not be personally identified in any way.

I agree to be personally liable for payment of all fees if any claim I have against any Health Fund, Work Cover or Third Party is rejected. Overdue accounts will be referred to a Debt Collection Agency. The costs incurred in obtaining payment will be added to the original outstanding amount.

Signature of Patient: _____ **Date:**_____/_____/____