



**Personal Details:**  Mr  Mrs  Ms  Dr  Other \_\_\_\_\_

**Surname:** \_\_\_\_\_ **Given Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Occupation:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_ **Post Code:** \_\_\_\_\_

**Phone:** Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

**Next of Kin:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Referring Practitioner:** \_\_\_\_\_ **Provider No:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Name of your General Practitioner:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **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:** \_\_\_\_\_

<b>Fees:</b>	Description	Item	Fee	Pensioner/ Health Care Card	Medicare Rebate
<b>Initial Consultation</b>		110	\$290.00	\$220.00	\$128.30
	Long (30-45 mins)	132	\$390.00	\$320.00	\$244.35
<b>Review Consultation</b>		116	\$140.00	\$100.00	\$ 64.20
	After long consult	133	\$185.00	\$145.00	\$112.30
<b>Prescriptions</b>			\$ 20.00		
<b>Bowel Preparation Kits</b>			\$ 20.00		
<b>Pill Cam</b>			\$100.00		

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:** \_\_\_\_/\_\_\_\_/\_\_\_\_