PATIENT DETAILS

Dr Peter Stavrou

Title: Dr / Mr / Mrs / Ms / Miss

Surname: _____ **Given Names:** _____

Preferred Name: _____ **Date of Birth:** _____

Occupation: _____ **Email:** _____

Postal Address: _____

City: _____ **Post Code:** _____

Telephone: **Home:** _____ **Work:** _____ **Mobile:** _____

Next of Kin name: _____ **Relationship:** _____ **Telephone:** _____

Medicare Card No: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Ref no :** _____ **Exp Date** ____/_____/_____

Pension Card No: _____ **(aged pensioner's only)** **Exp Date:** ___ / _____ / ____

Veterans Affairs: **Gold / White** (please circle) **No:** _____ **Exp Date:** ___ / _____ / ____

White Card Accepted condition: _____

PRIVATE HEALTH: **Name of fund:** _____ **Membership No:** _____

Have you been in your fund longer than 12 months? **Yes** **No** (please circle)

Does this cover you for treatment in a private hospital? **Yes** **No**

Usual Doctor: **Name of doctor**: _____

Practice Name & Address: _____

WORKCOVER **Claim Number:** _____ **Date of Injury:** _____

Employer & Address: _____

Insurance Company: _____ **State:** _____

Case Manager & Phone: _____

FINANCIAL INFORMATION

Medicare does not completely cover the cost of your consultation. The consultation fees charged by Dr Stavrou are as follows and is payable **IN FULL** on the day of consultation:

Initial Consultation- $200.00 **Subsequent Consult -$110.00**

It is a term of the provision of these services that the patient shall be liable for all debt collection fees and charges, including but not limited to agent fees, solicitor costs and disbursements in the event that the collection is required. Other fees apply for Workcover.
In the event that a Workcover claim is rejected, it is the patients full responsibility to cover the costs of the consultations. Other fees may be incurred for fractures and their management.
It is practice policy that we do not see or treat Third Party or Public Liability cases. Should you wish to change your status from private to Third Party or Public Liability claim for this injury then you treatment will not continue. Under no circumstances will Medico-Legal reports be provided.

CONSENT

I understand that payment of the account in full is my responsibility. I consent to the release and communication of information from or to any other medical provider for the purpose of my ongoing clinical management, ongoing clinical research and audit. Privacy Act (2000) details available upon request.

Signed: _____ Date _____