**Personal Details:** *Please complete this form & return it to the reception desk. Thank you*

|  |
| --- |
| Title: Mr 🞏 Mrs 🞏 Ms 🞏 Miss 🞏 Master 🞏 |
| Surname: | Given Names: |
| Email: | Date of Birth: |
| Address: |
| Suburb: | Post Code: |
| Phone (Home/Work):  | Mobile: |
| Medicare Card No: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ | Ref # \_\_\_ | Exp: \_\_ \_\_ / \_\_ \_\_/ \_\_ \_\_ |
| Health Care Card/ Pension Card Number:  | Exp: \_\_ \_\_ / \_\_ \_\_/ \_\_ \_\_ |
| Private Hospital Cover: Yes 🞏 No 🞏 | Membership No: |
| Private Health Fund Name: | Ref # \_\_\_ |
| DVA Number (if applicable):  | Colour: | Exp: \_\_ \_\_ / \_\_ \_\_/ \_\_ \_\_ |
| TAC Claim No (if applicable): | Exp: \_\_ \_\_ / \_\_ \_\_/ \_\_ \_\_ |
| Workcover Company (if applicable): | Workcover Claim No: |
| Case manager: | Phone No: |

🞏 Please tick the box if you are happy to receive recall notifications via email correspondence

**Doctor’s Details:**

|  |
| --- |
| Referring Doctor/Optometrist Name: |
| Current GP Name : | Phone No: |
| Clinic Name: |
| Clinic Address: |
| Suburb: | Post Code: |
| Clinic Phone No: | Fax No: |

**🞏** If you were referred by an Optometrist or Specialist please tick the box if you DON’T want a copy of the report sent to the GP

**Emergency Contact Details:**

|  |  |
| --- | --- |
| Contact Name: | Relationship: |
| Phone No: | Mobile: |

**Parent (account holder) Details:** *Please nominate which parent will be responsible for your child’s account (if under <16 years). Medicare will refund rebate into your account.*

|  |  |
| --- | --- |
| Account Holder Name: | Date of Birth:  |
| Medicare Card No: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ | Ref # \_\_ | Exp: \_\_ \_\_ / \_\_ \_\_/ \_\_ \_\_ |

**Fee’s:**

The professional fees charged at this practice reflect the level of training and experience of our specialists

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of consultation/test** | **Item No** | **Standard** | **Pensioner/ HCC** | **Medicare Rebate** |
| Initial paediatric consultation (0-9 years old or 14 years old with a developmental delay) | 109 | $300.00 | $240.00 | $163.90 |
| Initial adult consultation  | 104 | $200.00 | $160.00 | $ 72.75 |
| Review consultation  | 105 | $110.00 | $80.00 | $ 36.55 |
|  |  |  |  |  |
| **Additional tests: your doctor will discuss with you prior if required** |
| Visual field test (bilateral) | 11221 | $240.00 | $160.00 | $57.60 |
| Visual field test (unilateral) | 11224 | $130.00 | $80.00 | $34.75 |
| IOL Master (unilateral) | 11240 | $190.00 | $120.00 | $69.25 |
| IOL Master (bilateral) | 11241 | $285.00 | $200.00 | $88.15 |
| OCT (Optical Coherence Tomography) | N/A | $100.00 | $80.00 | N/A |
| Fundus Photography  | N/A | $60.00 | $50.00 | N/A |

The following payment methods are accepted: Cash/ Cheque/ EFTPOS/ Credit Cards/ American Express/ Diners.

The following surcharge rate applies:

|  |  |
| --- | --- |
| MasterCard Credit  | 1.50% |
| MasterCard Debit  | 0.50% |
| Visa Credit  | 1.30% |
| Visa Debit  | 0.40% |
| American Express | 2.80% |
| Diners | 2.80% |

*Privacy Agreement & Patient Consent:*

I understand that Inner South Eye Surgeons and associated Medical Centres comply with the Australian Privacy Law Act (2014). As part of their privacy policy, they are committed to protecting both the privacy of individuals as well as their personal information. By signing below I confirm that I have read the above and consent to the way Inner South Eye Surgeons collect, use, store and dispose of my personal information: the release of relevant personal information to relevant health professionals to ensure quality medical care; inclusion in national/state reminder systems, a recall register for follow up consultations, medical updates and health related information and the release of relevant personal information to my (prospective) employer, their authorized representative and/or insurer in work related cases. I understand I may withdraw my consent for Inner South Eye Surgeons to use and disclose my personal information, except where legal obligations are involved.

**All accounts are to be paid on the day of consultation**

I understand that appointments missed or cancelled without 24hrs notice may be charged in full to me. I hereby consent to Inner South Eye Surgeons sending a report to my referring doctor or optometrist. I agree to meet the cost of my medical treatment.

**Signature:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_