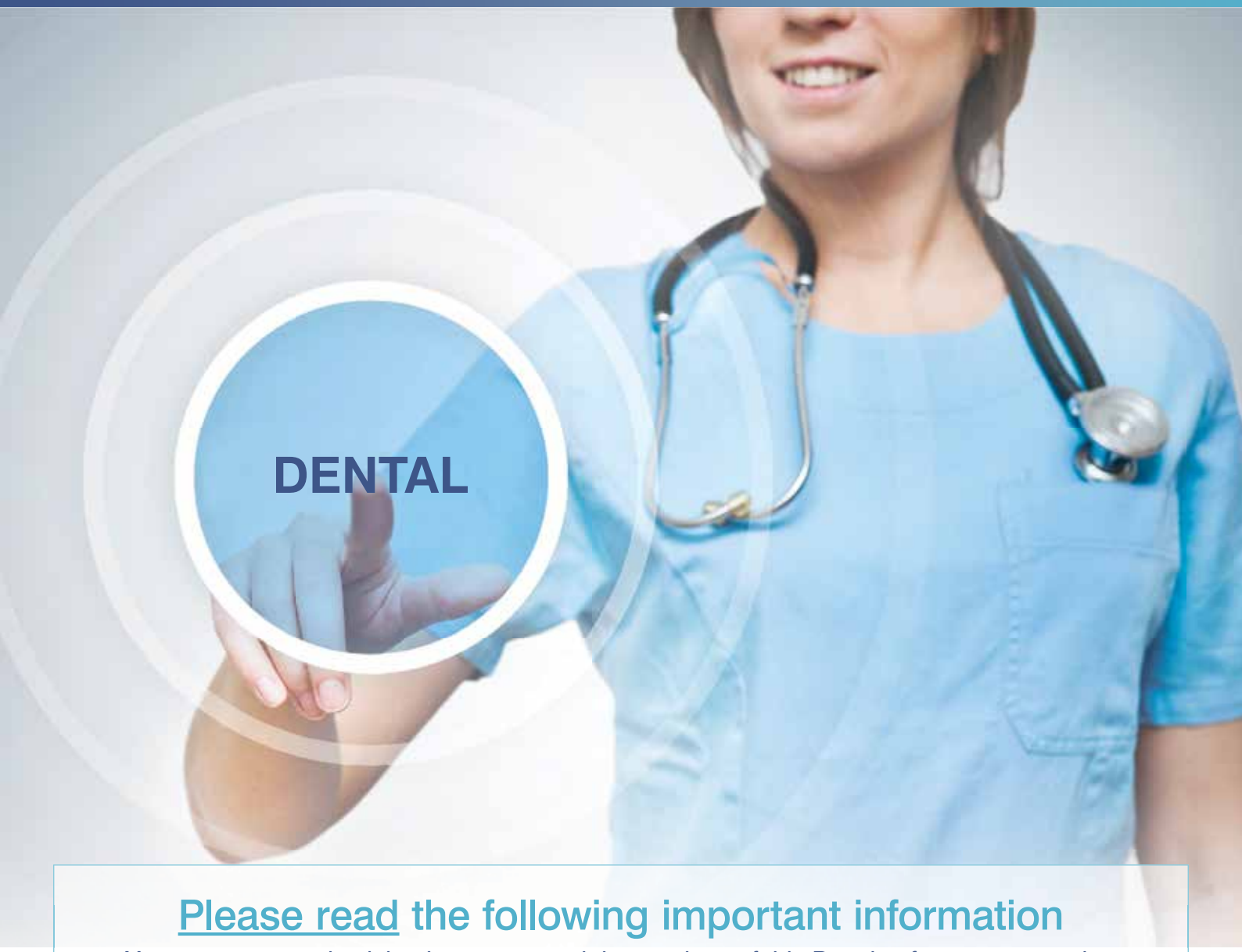
informed financial consent

ANAESTHETIC GROUP BALLARAT



Please read the following important information

Your surgeon or physician has requested the services of this Practice for your upcoming procedure. This document contains important information about your Anaesthetic Fee.

To ensure your surgery can proceed, you are required to pay your Anaesthetic Fee and complete and return the attached “Patient Details & Consent Form” and "Medical Assessment / Dental Procedure Form" at least 2 days prior to your procedure. Your form can either be returned in the reply paid envelope provided or emailed to reception@agb.com.au. Please retain this page for your records.

6 Drummond Street North, Ballarat, Victoria, 3350 | PO Box W183, Ballarat West, Victoria, 3350
Tel: 03 5331 4888 | **Website:** agb.com.au | **Email:** **reception@agb.com.au** | **ABN:** 37 076 746 843

your anaesthetist…

is a Specialist Doctor who provides you with a service independent of that provided by the surgeon or hospital. For your anaesthetic there is a separate fee. You will have an out of pocket cost for your anaesthetic, which needs to be paid prior to your procedure. The out of pocket cost varies between health funds due to the fact health funds reimburse the Specialist different amounts for the same procedure.

Please contact the Anaesthetic Group Ballarat if you have any questions about the contents of this document, any questions about your fee, or you are covered by a health fund that is not listed. Payment can be made at our office, 6 Drummond Street North. Alternatively please complete the credit card section on the last page of this form or attach a cheque.

These fees accurately reflect our current arrangement at the time of printing. However, patients are advised that fees may be subject to change without prior notice.

Your Private Health Fund and Medicare will be invoiced after your procedure to finalise your account. If they advise us your insurance is not sufficient to cover our account a further invoice will be sent to you.

We encourage our patients to be aware of the level of cover their particular policy provides, including waiting periods, exclusions and restrictions.

FEES VALID 1 JANUARY 2024 - 31 DECEMBER 2024

Dental **Out of pocket expenses**	AHSA* (Aus Health Services Alliance Funds) Australian Unity GMHBA GUHealth St Lukes	AHM BUPA HCF Medibank Private Mildura Health Fund	Latrobe Health Services	Australian Unity & Medibank Private BASIC not eligible for Gap Cover NIB	Uninsured Patients
General Dental (AGB Ref 11)	**$328.00**	**$341.00**	**$437.00**	**$497.00**	**$557.00**
Extended Dental (Over 2hrs) (AGB Ref 16)	**$477.00**	**$496.00**	**$636.00**	**$723.00**	**$810.00**

Please complete the enclosed Medical Assessment Form and submit with your Patient Details / Consent Form.

*** Australian Health Services Alliance Funds**
ACA Health Benefits Fund / AIA Health Insurance / Australian Unity Health / CBHS Health Fund / CUA Health / Defence Health / Frank Health Insurance / GMHBA / HBF Health / Health Care Insurance / Health Insurance Fund of Australia / Health Partners / Navy Health / Nurses & Midwives Health / Onemedifund / Peoplecare Health Insurance / Phoenix Health Fund / Police Health / Queensland Country Health Fund / Reserve Bank Health Society / Teachers Health Fund / The Doctors' Health Fund / TUH / Westfund

patient details / consent form

ANAESTHETIC GROUP BALLARAT

Patient details

Title | Given Name(s) | Surname

Previous Surname (If applicable) | Date of Birth / / | Gender

Unit No | Street No. | Street Name

Suburb | Postcode | Email Address

Postal Address (If different from above)

Suburb | Postcode

Home Phone | Mobile

Payment - Is the patient responsible for this account? ☐ Yes (go to next section) ☐ No (complete this section)

Title | Payer's Given Name(s) | Payer's Surname

Payer's Residential Address

Suburb | Postcode

Payer's Postal Address (If different from above)

Payer's Email Address | Payer's Mobile

NOTE: TO BE COMPLETED FOR CHILDREN UNDER AGE 16 REQUIRED BY MEDICARE FOR IDENTIFICATION

Payer's Date of Birth | Relationship to patient:

Payer's Medicare Number

Card No ☐☐☐☐☐☐☐☐☐☐ **ID Number** *Left of name* ☐

Operation details

Intended Procedure Description | Date of Procedure / /

Hospital
- ☐ Ballarat Day Procedure Centre (Howitt Street)
- ☐ Ballarat Health Services (BASE)
- ☐ St John of God Health Care
- ☐ Other
  If Other, please provide details:

Name of your Surgeon

Any concerns: We have a practice nurse on our staff. Please call our rooms on 03 5331 4888, (between 9am and 4pm) if you wish to discuss clinical aspects of your anaesthesia or medical history, at least 5 working days prior to your procedure.

Entitlements

Medicare

Card No | | | | | | | | | | | **ID Number** *Left of name* |

Concession Card Holder Details (If applicable)

☐ Health Care Card (green) ☐ Pension Card (blue)

Health Care Card (Green) CRN | | | | | | | | | | |

Pension Card (Blue) CRN | | | | | | | | | | |

Private Hospital Insurance Cover (Note: this does not include Extras only cover)

Fund Name | Member No

All Patients please ensure that you are aware of:
Your level of health insurance cover, Pre-existing condition rules, Exclusions & Restricted services.

Department of Veterans' Affairs (If applicable)

DVA | | | | | | | | | | | Gold ☐ White ☐

Workcover/TAC claim details (If applicable)

Employer | Phone

Address | Email

Insurance Company | Claim Case Number

Case Manager | Date of Injury

Contact Number | Email

Declaration

If I have private health cover, I give my permission for the Anaesthetic Group Ballarat to send the account for my anaesthetic and associated medical services directly to my health fund. I acknowledge that if my insurance is not sufficient to cover the fees, payment of this account is my responsibility.

I acknowledge that I have received written information which details information regarding the out of pocket costs to me of the anaesthetic service associated with my forthcoming procedure. I confirm that I have read and understood the information provided, and that I have been given the opportunity to contact the Anaesthetic Group Ballarat to receive information on any questions I might have.

Signature of Patient/Parent/ Guardian | **Date** / /20

Payment method for out of pocket costs

<u>Please note:</u> We will process this payment upon receiving this authorisation unless otherwise advised by you.

☐ VISA ☐ Mastercard Expiry date / CCV Amount **$**

Name on card | **Signature**

Card no | | | | | | | | | | | | | | | | |