Suite 66, Wexford Medical Centre
3 Barry Marshall Parade
MURDOCH WA 150

Suite 101, Specialist Medical Centre (West)
Joondalup Health Campus
60 Shenton Avenue
JOONDALUP WA 6027

PERSONAL DETAILS:
Dr / Mr/ Mrs/ Ms/ Miss/ Other (Circle one)

First Name:_____ Surname:_____

Date of Birth: _____ Occupation:_____

Address: _____

Suburb: _____ Postcode: _____

Phone - Home: _____ Phone – Work: _____

Mobile: _____ Email: _____

Medicare No: _____ Ref: _____ ***(small number in front of your name)***

For patients under 18: Parent/Guardian Medicare No: _____Ref: _____DOB: _____

Parent/Guardian Full Name: _____

Do you have Private Health Insurance YES / NO (Please circle) Hospital Cover YES / NO (please circle)

Name of fund: _____Membership No: _____

When did you join your private health fund? (approx.) _____

Dept of Veteran's Affairs Card No.: _____ Gold Card / White Card (please circle)

REFERRAL DETAILS:

Referring Doctor: _____ Suburb: _____

Usual Doctor: _____ Suburb: _____

EMERGENCY CONTACT / NEXT OF KIN DETAILS:

Next of Kin: _____ Relationship: _____

Phone: _____

FEES:	**Initial**	**$200**
	Follow up	**$100**
	Did not attend	**$50**
	Medical Reports/Insurance Forms	**From $150**

NB: A practice fee may be applied to your surgery fees. This will be at the discretion of the surgeon.

Medical Certificates, Centrelink and Carers Leave from will not be available until consultation has been paid.

Please note this clinic requires **payment on the day of consultation** and we can submit your account to Medicare for your rebate electronically. Failure to meet financial obligation may result in your account being submitted to our Debt Collection Agency at your further cost. You must advise the clinic of cancellations 24 hrs prior to a consultation or you will be charged the "Did not attend" fee.

Patients must give their consent (implied, oral or written) for personal information to be collected & used, as required by the Privacy Act 1988.

I provide my consent for Dr V Mukundala & Dr R Petanceski to collect, use and disclose my personal information as required by the Privacy Act 1988 (Patient Consent to Collect and Disclose Information is available for your perusal on request)

Signature:_____ **Date:** _____

THIS SIDE ONLY APPLIES TO WORKERS COMPENSATION & MOTOR VEHICLE ACCIDENT CLAIMS

FOR WORKERS COMPENSATION INJURY:

Name of Employer: _____

Address: _____

_____

Contact Number: _____

Date of Accident: _____

Employer's Insurance Company: _____

Claim Number: _____

If you do not know the above details, please check with your Employer and telephone the Surgeon's Rooms with this information **as soon as possible**. You will be liable for all invoices until all your workers compensation details have been provided.

MOTOR VEHICLE ACCIDENT INJURY:

Date of Accident: _____

Claim Number: _____

We require a "Letter of Acceptance" from the Insurance Commission of WA before forwarding invoices to ICWA.

Did your accident happen in WA? YES / NO (please circle)

AUTHORITY OF THE RELEASE OF INFORMATION

I _____ (your name) give permission for you to forward confidential information regarding my injury, the treatment I have received and guidelines for return to work to my Employer, Insurance Company and Rehabilitation Provider.

Signature: _____

Date: _____

This signature confirms that I have read the above statement and that I understand and agree with it.