

**PERSONAL DETAILS:**

Dr / Mr/ Mrs/ Ms/ Miss/ Other (Circle one)

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

Suburb: \_\_\_\_\_ Postcode: \_\_\_\_\_

Phone - Home: \_\_\_\_\_ Phone – Work: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

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

For patients 16 & under - Parent/Guardian Medicare No: \_\_\_\_\_ Ref: \_\_\_\_\_

Parent/Guardian Full Name: \_\_\_\_\_ Parent/Guardian DOB: \_\_\_\_\_

**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)

Usual Doctor: \_\_\_\_\_ GP CLINIC: \_\_\_\_\_

**EMERGENCY CONTACT / NEXT OF KIN DETAILS:**

Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

<b><u>FEES:</u></b>	<b>Initial/New Referral</b>	<b>\$300</b>
	<b>Follow up</b>	<b>\$150 (over 30 mins - \$200, over 45mins -\$280)</b>
	<b>Second Opinion</b>	<b>\$400</b>
	<b>Medical Reports/Insurance Forms</b>	<b>From \$150</b>
	<b><u>NB: A Gap fee may apply to your surgery fees</u></b>	

Medical Certificates, Centrelink and Carers Leave form 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: \_\_\_\_\_ Injury : \_\_\_\_\_

Employer's Insurance Company: \_\_\_\_\_

Claim Number: \_\_\_\_\_

If you do not know the above details, please check with your Employer and provide the details on or before the date of your appointment. **You will be liable for all invoices until liability of your workers compensation claim has been accepted.** Please provide a copy of the liability acceptance letter so we can forward invoices to the insurer.

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**MOTOR VEHICLE ACCIDENT INJURY:**

Date of Accident: \_\_\_\_\_ Injury: \_\_\_\_\_

Claim Number: \_\_\_\_\_

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

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

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**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.*