ESTIMATE OF MEDICAL FEES

Estimate of Medical Fees

As a service to our patients, we provide the following estimate of the likely medical costs you will be required to pay for your procedure. You should discuss these costs with the doctor or doctor's staff preferably before your procedure.

Please note that it is an estimate only. Unless specified, the estimate refers only to the fees charged by this practice. It does not cover services provided by other doctors, including radiologists, nuclear physicians and pathologists, nor other costs associated with your episode. eg. accommodation facility, pharmacy and physiotherapy.

In the event of unforeseen circumstances, it may be necessary to arrange additional medical services, resulting in further charges to you.

Patient's Details

Patient's Name

Patient's Address | State | Postcode

Health Fund Name | Hospital | Date of Admission / /

Procedure Details

Item number(s)/Description of Service(s)	Fee	Total benefits (Medicare/ Health Fund Benefit) – (See Note 1)(optional)	Patient Gap Payment – (see Note 2)(optional)
	$	$	$

You are likely to have a gap to pay ☐ Yes ☐ No *If yes, please refer to your Health Fund for additional information not provided above.*

☐ Pathology and ☐ Radiology services are likely to be required during your episode of care.

Any financial interests in products or services recommended or given to the patient have been disclosed to the patient ☐ Yes ☐ N/A

NOTES:

1. Total Benefit This includes the medical rebates payable by Medicare and your Health Fund which together provide a contribution to the cost of the medical service. For a no gap product it will equate to the practitioner's fee. For further information patients should approach their Fund.

2. Patient Gap Payment Where the Medicare and Health Insurance Fund rebates do not cover the entire cost of the medical service, the 'Patient Gap Payment' represents the part of the cost of the medical service which you, the patient, will pay yourself.

Patient/Guardian to complete

The above estimated costs have been explained to my satisfaction. I understand that the above costs are an estimate and subject to variation. It is not a consent to, nor a request for, a procedure.

Patient/Guardian's Signature | **Date** / /

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