**Patient Information**

**HOLLYWOOD HAEMATOLOGY GROUP**

Dr Bradley Augustson

Dr Chan Cheah

Dr Shane Gangatharan

**Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of birth**: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

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

Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tuesday, 24 April 2001Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare No: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ No. Next to your name \_\_\_\_\_ Expiry Date \_\_\_/\_\_\_\_\_\_ Health Insurance Fund: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Member No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pension Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry: \_\_\_/\_\_\_/\_\_\_\_\_

DVA: (please circle) Gold/White Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expiry: \_\_\_\_/\_\_\_\_\_\_\_

Seniors Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry \_\_\_\_/\_\_\_\_\_\_ Health Care Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry \_\_\_\_/\_\_\_\_

**NEXT OF KIN:**

Next Of Kin details: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GP Name & Details (if NOT referring Doctor):**

GP Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**FINANCIAL AGREEMENT:**

Full payment of consultation fees is required on the day of your consultation. I acknowledge that I am liable for all fees.

 **Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_/\_\_\_/\_\_\_\_\_**

HIC ONLINE/MEDICARE EASYCLAIM

**AUTHORISATION TO LODGE A PATIENT CLAIM (consent to claim you medicare rebate via our practice software at time of payment of consult)**

Do you authorise this location/practice to lodge this claim electronically with Medicare and for Medicare to pass the following enrolment and benefit information to this location for verification?

* The patient’s/claimant’s current Medicare card and issue number
* The patient’s/claimant’s first name and reference number
* Where applicable, display the benefit amount for each service.

If the amount is paid in **FULL** you can elect to have your benefit amount deposited by EFT.

 **Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_**