Informed Financial Consent & Personal Information and Health Record Access

We have a commitment to ensure that you are informed about your financial obligations. Depending on your health cover or insurance you may be responsible for a range of out-of-pocket costs. Dr Popovic is a "Known Gap Provider", which means that you may have an out of pocket expense for your surgical procedure provided by Dr Popovic. The maximum out of pocket expense that you will be charged per procedure/item will depend on your Health Insurance Fund.

This does not cover services provided by other doctors, such as anaesthetist, surgical assistant, radiologist, pathologist, or other costs associated with the procedure/stay in the hospital such as accommodation or pharmacy.

I understand that it is my responsibility to confirm with my health insurance fund the level of cover that I have. We are obliged to obtain your consent to acknowledge that you understand, please complete the 'Informed Financial Consent' below.

INFORMED FINANCIAL CONSENT

I have been advised that there will be an out-of-pocket cost associated with the service/s provided by Dr Popovic per procedure item. I understand that I will be responsible for any costs not covered by my health fund/insurer for Dr Popovic. I agree to pay any additional costs associated with my procedure/hospital admission.

Protecting your information and accessing your health record

Our staff are bound by strict legal duty of confidentiality. We maintain strict policies and practices with respect to who has access to personal information about you. Information will generally be collected from you and your general practitioner. In some circumstances we might need to access personal information and health record from another health facility about your diagnosis and treatment.

We will generally provide information about your care to your doctor and other specialists involved, and any special instructions related to your care.

I consent to the collection, use and disclosure of my personal information in accordance with the Privacy Act 1988 (QLD).

Name:	Signature	Date:

PATIENT DETAILS

Title:	**Surname:**	**First Name:**	
Middle Name:		**Date of Birth:**	
Address:			
Home Phone:	Mobile:	Work Phone:	
Email			
Next of Kin:	Surname:	First Name:	
Relationship:		Best contact Number:	
Usual GP			
Name of Clinic			
Medicare No:	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref ___ (No. next to your name) Expiry Date: ___ / _____		
Private Health Insurance	Name of Fund		
Membership Number			
TYPE OF COVER	BASIC COVER / FULL HOSPITAL COVER HOSPITAL COVER - SILVER BRONZE GOLD (PLEASE CIRCLE)		
If applicable	Pension/Concession Card Number: Expiry:		
DVA Number		Gold/White	
ALL PATIENTS: Please complete and sign this authority.			
I, (Name)_____ am aware that there will be a fee of $140 (Medicare Rebate $76.80) charged for my initial consultation and I consent to the collection, use and disclosure of my personal information in accordance with the Privacy Act 1988 (Qld).			
Signed: **Date:**			

E: reception@coastalgeneralsurgeons.com.au
www.coastalgeneralsurgeons.com.au
P: 07 5353 7145 F: 07 5302 0703
M: 0468 488 444