EAST ST KILDA EYE CLINIC

DR GARY L LEBER
EYE SURGEON
034880BH

DR PHILIP HOFFMAN
EYE SURGEON
219165CY

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CONFIDENTIAL PATIENT REGISTRATION

Personal Information

Title (circle) Mr Mrs Ms Miss Mast Dr Prof Other: _____

Surname: _____ Given Name: _____ DOB: _____

Address: _____ Suburb: _____ Postcode: _____

Phone: Home: _____ Work: _____ Mobile: _____

Email: _____

Next of Kin/ Emergency Contact

Full Name: _____ Relation: _____ Contact Number: _____

Are you an Aboriginal and/or Torres Strait Islander? YES / NO

Medicare Details

Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref (before name): _____ Exp: _____/_____

(If applicable) ***Pension Card Number:*** _____ Exp: _____

(If applicable) ***Health Care Card Number:*** _____ Exp: _____

(If applicable) ***DVA Card Number:*** _____ Exp: _____

Private Health Insurance

Fund Name: _____Membership Number: _____

GP Details

DR: _____ Clinic Name: _____

Phone:_____ Address: _____

Optometrist Details

Name: _____ Business Name: _____

Consultation Fees

You will be charged ONE of the consultation fees listed below depending on your circumstances

	Full Fee	Pensioner	Health Care Card	Medicare Rebate
Initial Consultation:	$290.00	$170.00	$200.00	$81.30
Review Consultation:	$160.00	$120.00	$120.00	$40.85
Long term review	$290.00	$170.00	$200.00	$40.85

PLEASE NOTE: Any tests or procedures additional to the consultation fee will be advised.

Common Tests	Full Fee	Pensioner	Health Care Card	Medicare Rebate
OCT	$180.00	$100.00	$130.00	NO REBATE
Visual Fields	$250.00	$130.00	$150.00	$63.50
A Scan (for cataract surgery)	$330.00	$200.00	$230.00	$97.00
VICROADS Eyesight Report	$165.00	$110.00	$110.00	NO REBATE
VICROADS Eyesight (Report + Visual Fields)	$330.00	$165.00	$220.00	NO REBATE

Agreement

I understand that this Practice handles personal information in accordance with the National Privacy Principles enshrined in the Commonwealth Privacy Act 2012.

I may gain access to my medical information, or provide permission for others to do so, by contacting East St Kilda Eye Clinic with a written and signed request.

I consent to the handling and sharing of my information by this Practice for the purpose of my health care, and for any associated administrative and billing purposes. I agree that photos/images may be obtained for my treatment, and for my Medicare or health fund requirements.

I hereby agree to pay all associated fees relating to my consultation/s, tests and/or surgery or other expenses incurred in my treatment. I acknowledge that if an account is overdue, the Practice reserves the right to refer the account to a Collection Agency. I agree to meet all costs and commissions incurred in employing the said Agency to collect the overdue account.

I have read, understood and agree to all the above.

Signature: _____ Date: _____ / _____ / 20_____