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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: ☐ as per referral

DR: _____ Clinic Name: _____

Phone: _____ Address: _____

Optometrist Details: ☐ as per referral

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:	\$320.00	\$180.00	\$200.00	\$86.15
Review Consultation:	\$175.00	\$120.00	\$120.00	\$43.35
Long term review	\$320.00	\$180.00	\$200.00	\$43.35

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	\$210.00	\$110.00	\$140.00	NO REBATE
Visual Fields	\$290.00	\$140.00	\$150.00	\$67.25
A Scan (for cataract surgery)	\$370.00	\$220.00	\$240.00	\$102.85
VICROADS Eyesight Report	\$220.00	\$165.00	\$165.00	NO REBATE
VICROADS Eyesight (Report + Visual Fields)	\$330.00	\$220.00	\$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_____