

# 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 in-hospital or day surgery elective procedure.

You should discuss these costs with your doctor or doctor's staff and your health insurer **before** your procedure to be sure you understand what costs you may be liable to pay yourself. You will be liable for any costs not covered by Medicare or your health fund.

Please note that this is an **estimate** only of the fees charged by this practice.

Unless clearly stated, it does not cover services provided by other doctors, such as anaesthetists, radiologists, nuclear physicians or pathologists, or other costs associated with your stay in the hospital or day surgery unit, such as accommodation, pharmacy, physiotherapy or other allied health services.

As with any medical procedure, if unforeseen circumstances arise during the procedure it may be necessary to arrange additional medical services or use a different or more costly prosthetic device or implant. If this happens there may be additional costs to you that are not covered by this estimate.

## ESTIMATE OF MEDICAL FEES

This is an estimate of medical fees only. It does not cover costs of medicines (e.g. including those listed on the Pharmaceutical Benefits Scheme (PBS) or not listed on the scheme i.e. non-PBS), drug administration and related costs that may be incurred for certain treatments (e.g. chemotherapy or other medications for cancer), particularly for ongoing treatment that extend over a long period of time.

### PATIENT'S DETAILS

To be completed by the patient

Family name:		First name	
Address:			Suburb/City:
State:	Postcode:	Date of birth: __/__/____	
Hospital:			Admission date: __/__/____
Medicare: Yes <input type="checkbox"/> (number) _____ No <input type="checkbox"/>			Health fund:

To be completed with the treating practitioner

MBS Item No	Description	Doctor's Fee	Medicare Benefit	Health fund benefit (estimate)	Estimated patient gap
Total:					

### OTHER RELATED SERVICES (if applicable)

Type of Service (Tick if likely to be involved)	Estimate of Fee or Charge	Contact for fee information (if known)
Anaesthetist <input type="checkbox"/>		
Assistant Surgeon <input type="checkbox"/>		
Pathology <input type="checkbox"/>		
Imaging <input type="checkbox"/>		
Devices/Implants <input type="checkbox"/>		
Other health professional <input type="checkbox"/>		
Other health professional <input type="checkbox"/>		

### DECLARATION BY PATIENT OR GUARDIAN:

I understand that this is an estimate only and may be subject to variation. I acknowledge that it is my responsibility to confirm with my health insurance fund the level of cover that I have and any amount that it will be my responsibility to pay. I have been advised that other health professionals may be involved in my treatment and I understand that this estimate does not include their fees or charges unless specifically stated otherwise.

Patient or Guardian's signature:	Date: __/__/____
Guardian's full name:	