

ASSOCIATE PROFESSOR GREG BAIN

PERSONAL DETAILS

DR / MR / MST

MRS / MISS / MS

_____ (SURNAME)

_____ (GIVEN NAMES)

ADDRESS

_____ POST CODE _____

DATE OF BIRTH _____

TELEPHONE NO: (Home) _____

(Mobile) _____

(Work) _____

(Email) _____

FAMILY DOCTOR'S NAME AND ADDRESS _____

PERSON RESPONSIBLE IF PATIENT IS A MINOR _____

D.O.B. _____

MEDICARE NO _____

REF NO ____

EXP ____ / ____

VET AFFAIRS NO _____

PRIVATE HEALTH INSURANCE FUND _____

MEMBER NO _____

IS THIS A WORKERS COMPENSATION CLAIM?

YES / NO

IS THIS A THIRD PARTY / INSURANCE CLAIM?

YES / NO

As I am seeking private treatment I acknowledge that payment of accounts is my responsibility and that all accounts must be paid within 30 days or others costs may be incurred through a debt collection agency. Associate Professor Bain charges above the Schedule Fee. (Medicare pays only 75% - 85% of the Schedule Fee.) **THERE WILL BE GAP PAYMENTS APPLICABLE ON CONSULTATIONS. FULL PAYMENT OF THE ACCOUNT IS REQUIRED ON DAY OF CONSULTATION.** If a WorkCover or Third Party Claim is rejected all outstanding accounts become the responsibility of the patient. I acknowledge and consent that information I have provided on this form may be provided to a third party for purposes related to my health care.

SIGNED _____

DATE _____