DR 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

NAME AND ADDRESS OF EMPLOYER ____

____

NAME AND ADDRESS OF WORKCOVER AGENT ____

____

CLAIM NO ______________________ DATE OF INJURY ______________

IS THIS A THIRD PARTY / INSURANCE CLAIM? YES / NO

SOLICITOR'S NAME AND ADDRESS ____

____

CLAIM NO ______________________ DATE OF ACCIDENT ______________

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. Dr 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 ______________