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 **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 otherwise 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 or physiotherapy.

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

ESTIMATE OF MEDICAL FEES

PATIENT'S DETAILS

Family Name				**Given Names**		
Address					**Suburb/City**	
	State		**Postcode**		**Health Fund**	
Hospital					**Admission Date**	

PROPOSED PROCEDURE DETAILS

these columns are optional

MBS Item No	Description	Fee	Medicare benefit (please confirm)	Health fund benefit (please confirm)	Estimated patient gap

OTHER SERVICES

There may be a need for other services to be provided for this procedure including:

Type of Service Tick if likely to be involved		Estimate of Fee or Charge	Medicare Benefit (please confirm)	Health Fund Benefit (please confirm)	Patient Gap	Contact for fee information (if known)
Anaesthetist	☐					
Assistant Surgeon	☐					
Pathology	☐					
Radiology	☐					

PROSTHETICS

Prosthetics (implanted medical devices used in surgery) required for this treatment? YES ☐ NO ☐

Device description	Reference Number	Full Charge	Health Fund benefit (please confirm)	Patient has amount to pay? YES*	NO
				☐	☐
				☐	☐

NOTE * If there is a patient amount to pay, ask your doctor for the reasons this prosthesis was chosen.

Any financial interests this practice has in products or services recommended or to be given to you have been disclosed and explained.

☐ Yes ☐ Not applicable

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 further acknowledge that I have been informed of the possible cost of any prosthetic device that may be required for the procedure. 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			