INFORMED FINANCIAL CONSENT

As a service to our patients, we provide the following estimate of the likely medical costs you will be required to pay for your obstetric, in-hospital or day surgery elective procedure.

You should discuss these costs with your doctor or doctor’s staff **before** you commence obstetric care or 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 obstetric and medical procedure, if unforseen circumstances should arise during the procedure it may be necessary to arrange additional medical services, perform an additional procedure 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. Please also note that you may receive an additional invoice post- surgery for any additional procedure performed at the time of your surgery which was not initially quoted for or anticipated.

|  |
| --- |
| 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 |  |
| Patient or Guardian’s full name |  |