Dr D A CUTTING

PLEASE FILL IN UNSHADED SPACES DESIGNATED WITH A * THEN HAND IN TO RECEPTION. THANK YOU.

1	15
2	16
3	17
4	18
5 *** Surname**	19
6 *** Christian Name**	
7 *** No & Street**	21
8 *** Suburb**	22
9 *** Postcode**	23
10 *** Tel Home**	7
11 *** Tel Work/ Mobile**	8
12 *** Date of Birth**	9
*** eMail:**	
*** Father's Name**	*** Mother's Name**
14 *** Medicare №**	**Account Responsibility:** Father Mother Other
*** Do You Recieve a :- Pension ?** Yes / No **Number :** **Expires :**	
Health Care Card ? Yes / No **Expires :**	
*** Reason :** For card / pension	

See Below

FEES / REFERRALS

Most professionals charge fees set by their professional organisations. The federal government, via Medicare, has set a range of fees that it would like the medical profession to charge (**Schedule Fee**). A **Gap** exists between the fee charged and Your Rebate received back from Medicare. Federal legislation prevents patients from insuring against this. Different in Private Hospitals.

I set my fees between those of the Australian Medical Association (AMA) and the Government fee. I discount for unemployed, pensioners and some Health card holders. **I will not Bulk Bill.** Payment of the full account is to be made on the day of consultation (unless otherwise arranged). A discount is made for full payment on the day.

Referrals are required to gain your higher rebate. **GST :** Does not apply to Medical Services / Medical appliances. .

NON ATTENDANCE - without reasonable notification (at least 24 hrs) will incur a fee of $50

Fee Type	Initial Complex Item 132	Review Complex Item 133	Initial Single Item 110	Review Single Item 116
Rebate	259.40	129.90	137.65	68.90
My Fee	**485.00**	**250.00**	**360.00**	**190.00**
Gap	**225.60**	**120.10**	**222.35**	**121.10**

I have read the above fees note: .....

Dr D A CUTTING
MBBS FRACP
Allergist and Paediatrician
102 Anderson St., Lilydale 3140 ph (03) 9739.7250 fx (03) 9739.7260
dac@melbpc.org.au www.drdcutting.com.au

We require your consent to collect personal information about you and your child. Please read this information carefully, and sign where indicated below.

This medical practice collects information from you regarding your child for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in health care needs. This means we will use the information you provide in the following ways:

- Administration purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your child's care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Disclosure to other doctors in the practice, locums, medical students and by Registrars attached to the practice for the purpose of patient care and teaching. Where applicable we may also need to communicate with teachers, psychologists and other professionals involved with your child. Please let us know if you do not want your records accessed for these purposes. This will be noted accordingly.
- In an emergency situation where it is in the best interest of your child's health care we would disclose appropriate information if requested to do so.

I have read the information above and understand the reasons why this information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to my child.

I am aware of my right to access the information collected about my child, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitation on access or disclosure that I notify the practice of

PRINT FULL NAME: ..... **DATE:** ..... / ..... / .....

SIGNATURE: .....