

MR PAUL SIMPSON
F.R.A.C.S, MBBS/LLB
REGISTRATION FORM
(Please Print)



| Today's date: | | | | | | |
|--|----------------------------------|--------------------|-------------|---|---|--------|
| PATIENT INFORMATION | | | | | | |
| Patient's last name: | | First: | Middle: | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Other: |
| Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No | If not, what is your legal name? | Birth date: / / | | Age: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | |
| Street address: | | Mobile: | | Home phone no.: | | |
| Suburb: | | Post Code: | | () | | |
| Postal Address/ Email: | | | Occupation: | | | |
| Regular Doctor: | | | | | | |
| Other family members seen here: | | | | | | |

| INSURANCE INFORMATION | | | |
|--|-------------------------|-----------------------------|--|
| Person responsible for bill: | Address (if different): | Home phone / mobile number: | |
| Medicare Number (10 digits) | | | |
| Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Private Health Insurance name and membership number: | | | |
| Pensioner card number: | DVA number: | HCC number: | |

| IN CASE OF EMERGENCY | | | |
|---|--------------------------|-----------------|------------------------|
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work/Mobile phone no.: |
| <p>The above information is true to the best of my knowledge. I agree with the terms and conditions stated. I am aware that I need to settle the account for any out of patient appointments at the time of the appointment. I authorise my insurance benefits to be paid directly to Mr. Simpson and I understand I am financially responsible for any copayments.</p> | | | |
| <hr/> <i>Patient/Guardian signature</i> | | | <hr/> <i>Date</i> |

More Information

Current Medications:

Relevant Family History:
(Please include family member and condition/illness)

ERMS AND CONDITIONS

Mr Paul Simpson consults from Suite 27 at Cabrini Malvern. He operates at Cabrini Malvern, Glen Iris Private Hospital, The Avenue Hospital and Epworth Hospital.

Rooms:

Suite 27 Cabrini Medical Centre
Isabella St
Malvern 3144

Ph: 9509 5592
Fax: 9576 0318
email: simpsonpa@ccgroup.net.au
www.mrpaulsimpson.com.au

FEES:

Please note that this is **not** a bulk-billing practice.

Fees are calculated from the Medicare Schedule and AMA (Australian Medical Association) Recommendations.

Paul's fees are as follows:

| | Standard | With Sigmoidoscope | Medicare Rebate |
|----------------------|----------|--------------------|---------------------|
| Initial Consultation | \$160.00 | \$255.00 | \$72.55 or \$115.00 |
| Review Consultation | \$90.00 | \$185.00 | \$36.55 OR \$84.40 |

It is the patient responsibility to ensure that:

- **Payment of fees is made at the time of consultation. We accept, Cash, Cheque, credit card or EFTPOS**
- **We are provided with a valid referral, in order to claim the Medicare rebate**
- **Their health fund policy does not have a waiting period or pre-existing condition clause, failure to do so may result in the health fund requiring the patient to pay all costs relating to surgery**
- **Any out of pocket costs from surgery are settled with 14 days of receiving the invoice.**

PLEASE NOTE:

If your account exceeds our trading terms and conditions and is passed over for collection, the patient is liable for all reasonable expenses (including contingent expenses such as debt collection commission) and legal costs (on a full indemnity basis) incurred by Mr Paul Simpson for enforcement of obligations and recovery.