Northpark Private Hospital
Main Building, Suite 1, Level 1
Cnr Plenty & Greenhills Rds
Bundoora VIC 3083

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Mr/Mrs/Miss/Ms/Mast Date of Birth:_____ RCH _____

Given Names:_____ Surname:_____

Address: _____

Suburb: _____ State:_____ Post code:_____

Email:_____

Home:_____Work:_____Mobile:_____

Medicare No:_____ Ref No:___ (this is to the left of the patient's name on the card)

Expiry Date:___/___ Veteran's Affairs No:_____

Next of Kin (NOK) Name:_____ NOK D.O.B:_____

NOK Relationship:_____ NOK Phone No:_____

Account Holders Medicare Number:_____ Ref No:_____

Emergency Contact (Different from NOK) _____Phone No:_____

Private Health Fund:_____ Membership No:_____

Referring Doctor:_____ GP:(if different)_____

Clinic & Address:_____

Fee Policy: All consultation fees are due and payable on the day of consultation. The practice does not routinely bulk bill patients. Procedures are in addition to the consultation; please refer to fee schedule for costs. The costs for audiology and any surgical procedures will be discussed, if necessary, with you during consultation. DVA, TAC and Workcover are also charged at different rates. Failure to attend a booked appointment, without prior notification, will incur a fee. By signing this form you are agreeing to the practice fee policy.

Privacy Statement: This practice handles personal information in accordance with the Victorian Health Records Act and the Commonwealth Privacy Act. I consent to the handling of my information by this practice for the purpose of providing quality health care, associated administrative and billing purposes. I give permission for medical information to be obtained from any other source in order to help with my treatment. I also give permission for medical photography to be used for planning procedures and follow up. Use for teaching, audit research or publication would require additional consent to be obtained.

I have read the above fee policy and privacy statement. I consent to the taking and use of my medical records as described. I have viewed the fees and agree to pay the costs of consultations and any surgical procedures performed.

Name:_____

Signature:_____Date:_____

Dr Caroline Ryan
Ear, Nose & Throat Surgeon
MBBS (hons), FRACS, PDipAnat
BMedSc, MBBS (Hons)