Dr John Garvey FACS FRACS - ***REGISTRATION DETAILS AND FINANCIAL CONSENT***

Mr/Mrs/Miss/Ms/Dr/Prof GIVEN NAME(s): SURNAME:

Sex: M / F Marital Status: DOB: / / Age: Occupation:

IF UNDER 18, Name of parent/guardian & contact number:

Street address: Postcode:

Phone (H): (W): (MOB): email:

Medicare No.: No. On Card: Expiry Date: /

Health Fund: Fund Member No.: Pension/DVA No.:

Referring Dr: Date of Referral:

Name & Address of GP (if not referring Dr):

Next of kin & relationship: Phone:

Do you smoke cigarettes? ☐No ☐Yes / How many per day?

Do you drink alcohol? ☐No ☐Yes / How much per week?

Any current medication/injections? ☐No ☐Yes /Please name:

Past medical conditions/operations:

ARE YOU ALLERGIC TO MEDICATION? ☐ No ☐ Yes / Circle: PENICILLIN / SULPHUR / OTHER:

Have you ever had a blood transfusion? ☐ No ☐ Yes / If Yes when:

Method of Payment: ☐ Cash ☐ ☐ Credit Card : Card No Exp:

- **Dr Garvey does not "bulk bill" to Medicare for hospital operations or procedures. All operations and procedures are charged at twice the AMA rate. Should you require an operation you will be provided with an estimate of cost of your operation at the time of your consulation .**
- **All blood-thinning medication such as ASPIRIN, WARFARIN, CARTIA, CELEBREX, etc, MUST BE STOPPED ONE WEEK (7days)before your operation. Dr Garvey is most happy to answer any questions you may have about your operation and encourages you to discuss any possible adverse effects of your surgery. Dr Garvey has no financial interest in any of the Institutions where services may be provided.**
- **If you require a Medical Certificate or Medical Report on your condition, these will be provided after your account has been paid in full.**
- **Payment is due at the time of consultation. Medicare rebates are not available through our rooms .Medicare offices will process your Claim .**

I hereby accept full responsibility for the payment of all my outstanding debts, including any associated legal or recovery costs related to my treatment and if required an order will be sought from the Court for costs against you. I confirm understanding of this by my signature.

I confirm that I have read/had read to me, and fully understand the above notice.

Your signature Date:

Witness: Signature: Date:

An Eligible witness is any person that sees you sign this document please ensure you have your signature witnessed as this is required . Thank you

Authority for Use and Release of Medical Information

I .... hereby authorise Dr JFW Garvey to request any medical information, medical imaging records and medical records on my behalf to be forwarded to him at the above address and I agree to my non identifying medical information being compiled for teaching and research purposes.

Your signature:____**Date:** ______________

I am agreeable to collation of results for participation in non identifying outcome research. **YES** **NO**