DR SHANNON SIM
ORTHOPAEDIC SURGEON

Surname: _____ **Given Names:** _____

Preferred Name: _____ **Date of Birth:** _____

Occupation: _____ **Email:** _____

Postal Address: _____ **Postcode:** _____

Telephone: Home: _____ **Work:** _____ **Mobile:** _____

Next of Kin: Name: _____ **Relationship:** _____ **Telephone:** _____

Medicare Card: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ **Ref No: (No Next to Name)** ____ **Exp Date** ____ / ____

Veterans Affairs: Gold Card _____ **White Card:** _____

PRIVATE HEALTH INSURANCE

Name of Fund: _____ **Membership No:** _____

Have you been in your fund longer than 12 months? Yes No

Does it cover you for treatment in a private hospital? Yes No

WORKCOVER CLAIM

Claim Number: _____ **Date of Injury:** _____

Address of Employer: _____ **Employer:** _____

Claims Manager Name: _____ **Claims Manager Phone No:** _____

USUAL DOCTOR / GP **Name of doctor**: _____

Practice Name & Address: _____

FINANCIAL INFORMATION

Initial Consult: $**200** Subsequent Consult: $150

ACCOUNTS ARE PAYABLE IN FULL ON THE DAY OF CONSULTATION

It is a term of the provision of these services that the patient shall be liable for all debt collection fees and charges, including but not limited to agent fees, solicitor costs and disbursements in the event that the collection is required.
Please note that Medicare does not completely cover the cost of your consultation.
Other fees apply for Work Cover.
Other fees may be incurred for fractures and their management, plaster casts, boots, injections, splints etc
To cancel or reschedule your appointment with Dr Sim we require 24 hours notice. Given the high demand for our service with sufficient notice given for cancellation we can arrange another patient to take the appointment time. However, if you fail to provide 24 hrs notice to cancel your appointment you will need to pay a cancellation/non-attendance fee of $85. Missed appointments will incur a $50 fee. Please be aware that Medicare or Private Health Fund rebates do not apply for missed appointments. If you are attending under WorkCover, you will be required to cover the cost of the administration fee personally.

CONSENT

I understand that payment of the account in full is my responsibility.
I consent to the release and communication of information from or to any other medical provider, for the purposes of my ongoing clinical management and for ongoing clinical research and audit. Privacy Act (2000) details are available upon request.

Signed: _____ **Date**: _____