

# Informed Financial Consent

## Completion of this form is:

- the doctor's/provider's estimate of all fees.
- the patient's/guardian's acceptance of those fees.
- Westfund's agreement to pay the stated benefits for nominated services in a hospital or day surgery unit by the doctor and/or other providers named on this form.

## Member, Patient or Parent/Guardian to Complete

Member	Membership Number: _____
	Member's Full Name: _____ <small>First / Middle / Surname</small>
	Member's Address: _____ P/Code: _____

Patient	Patient's Name: _____ <small>First / Middle / Surname</small>
	Patient's Address: _____ P/Code: _____
	Patient's Relationship to Member: _____ Patient's Medicare Number: _____

## Doctor to Complete

Doctor/ Provider	Doctor's/Provider's Name: _____
	Provider Number: _____

Professional Services	Description of Service/Procedure: (NOTE: In the event of unforeseen circumstances it may be necessary to arrange additional services, resulting in further charges.) _____ _____
	Provider Number: _____
	Name of Facility: _____ Admission Date: ____/____/____ <small>Day Month Year</small>

Estimate of Fees	Service	Service Providers	Provider Numbers	MBS Item Numbers	Provider Estimated Charge
	1				
	2				
	3				
	4				
	5				

Signature	(refers to patient, and all information provided by Doctor)
	Any financial interests in products or services recommended or given to the patient have been disclosed to the patient/guardian Yes <input type="checkbox"/> Not Applicable <input type="checkbox"/>
	Doctor's Name (Print): _____
	Signature: ..... Date: ____/____/____ <small>Day Month Year</small>



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