

	Ph 1300 952 808	Fax (03) 9429 3627	
admin@melbentgroup.com.au			

PATIENT REGISTRATION FORM

GIVEN NAMES	SURNAME			
DATE OF BIRTH				
EMAIL ADDRESS				
ADDRESS	POSTCODE			
NDIGENOUS STATUS (Select all that a	pply)			
[ ] Aboriginal [ ] Torres S	Strait Islander [ ] Neither [ ] Not Stated			
MEDICARE	REF # EXP			
VETERAN'S AFFAIRS (IF APPLICABLE)	[] GOLD [] WHITE [] BLUE			
Do you have private health insurance v	with hospital cover? [ ] YES [ ] NO If Yes:			
NAME OF FUND	MEMBERSHIP No.			
ISLIAL CD.	Name of Practice:			
	Name of Practice:			
	Name of Practice:			
Address of Practice:				
Address of Practice:	RELATIONSHIP TO PATIENT			
Address of Practice:				
Address of Practice:         NEXT OF KIN	RELATIONSHIP TO PATIENT DATE OF BIRTH:			
Address of Practice:	RELATIONSHIP TO PATIENT DATE OF BIRTH:			
Address of Practice:         NEXT OF KIN	RELATIONSHIP TO PATIENT DATE OF BIRTH: patient is under 18 years old)			
Address of Practice:	RELATIONSHIP TO PATIENT DATE OF BIRTH: patient is under 18 years old) DATE OF BIRTH			
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Address of Practice:	RELATIONSHIP TO PATIENT         DATE OF BIRTH:         patient is under 18 years old)            DATE OF BIRTH            DATE OF BIRTH            DATE OF BIRTH            POST CODE         REF #       EXP			
Address of Practice:	RELATIONSHIP TO PATIENT         DATE OF BIRTH:         patient is under 18 years old)			
Address of Practice:	RELATIONSHIP TO PATIENT         DATE OF BIRTH:         patient is under 18 years old)            DATE OF BIRTH            DATE OF BIRTH            DATE OF BIRTH            DATE OF BIRTH			
Address of Practice:	RELATIONSHIP TO PATIENT         DATE OF BIRTH:         patient is under 18 years old)         DATE OF BIRTH         POST CODE         POST CODE         REF #       EXP         Ext one)         Specialist       ] Friend / Word of Mouth       ] Melb ENT Group Website         Media       [ ] Dentist       [ ] Other			
Address of Practice:	RELATIONSHIP TO PATIENT			



CONSULTATION FEES - Prices correct as of July 2022 and subject to change without previous notice.

DESCRIPTION	FEE	MEDICARE REBATE	OUT OF POCKET (APPROX)
104 New Consultation – In-Person	\$225	\$78.05	\$146.95
105 Review – In-Person	\$125	\$39.25	\$85.75
91822 New Consultation- Videoconference	\$138.25	\$78.05	\$60.25
91823 Review - Videoconference	\$94.35	\$39.25	\$55.10
91832 New Consultation - Telephone	\$138.25	\$76.80	\$61.45
91833 Review - Telephone	\$94.35	\$39.25	\$55.10
**41647 Ear Toilet	\$165	\$98.75	\$66.25
**41764 Nasendoscopy (camera Nose/throat)	\$205	\$110.40	\$94.60
**41677 Nasal cauterisation	\$145	\$80.90	\$64.10
**41501 Stroboscopy	\$255	\$166.80	\$88.20
**38428Trans-nasal Bronchoscopy	\$400	\$221.55	\$178.45
**41626 Intra-Tympanic Steroid	\$300 for 1 <sup>st</sup> injection	\$129.45	\$170.55
	\$200 for subsequent injections	\$129.45	\$70.65
**18244 Vagal Nerve Block	\$150	\$90.65	\$59.35
Nasal FB Removal (item number TBA)	\$125	\$68.00	\$57.00

## AUDIOLOGY PROVIDED BY RICHMOND AUDIOLOGY --- HTTPS://WWW.EASTERNAUDIOLOGY.COM.AU/LOCATION/RICHMOND/

Private Patient-1hour	\$180
Specialist Patient-30min /. Review ½ hour (\$100)	\$120

## Initial Consultation

Your first consultation fee will be \$225 with \$50 paid upon booking and the balance remaining to be paid on the day of your appointment. If you have a valid referral you will receive a Medicare rebate that can be lodged at the time of your appointment.

## **\*\*Additional Costs**

Please note that if any procedures are performed during your consultation, new or review (e.g. nasal endoscopy, nasal cautery, ear toilet), additional charges will apply on top of the consultation fees, with the whole account being payable on the day.

The practice does not bulk bill, nor offer payment plans. See our website for further fee details: (https://melbentgroup.com.au/patient-registration-form/)

By signing this document you acknowledge our Consulting fees, deposit terms, and agree with our Cancellation & Privacy Policy. Should you have any queries please contact the front desk staff or visit our website before signing this document.

SIGNATURE OF PATIENT (OR RESPONSIBLE GUARDIAN)

\_\_\_\_\_ DATE \_\_\_\_

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