Informed Financial Consent for patients with Medicare and Private Health Cover: Gynaecology

This document contains information about the cost of your health care with me, Dr Liza Fowler and my team at Wellbeing of Women Centre. We undertake to provide you with professional care and to provide you with all information and guidance necessary to make the right decisions about your health
The fees you pay enables us to provide this service and it also contributes to a very large indemnity fee compulsory for all Gynaecology practices.
The consultation and office procedure fees are payable in full following your visit via cash/card. We will submit claims to Medicare on your behalf who will pay your rebate directly into your nominated bank account.

For inpatient services, I am a **NO GAP provider** so there will be no extra out of pocket expense for my services in hospital. These fees do not cover other services provided externally by for example the Anaesthetist, the Paediatrician, Pathology, Radiology or in office procedures. *Please note it is the patient's responsibility to check they have the suitable level of coverage with their Health Fund.*

N.B Fees are subject to change without notice, please ask reception if you have any questions relating to the fee schedule.

Fees in table below are for outpatient services provided in our office that are eligible for a Medicare rebate only

MBS code	Service	Fee	Medicare Rebate
104	New Gynaecology appointment	300	81.30
105	Follow up visit	150	40.85
105	Post-op appointment	100	40.85
105	Follow up visit *(long consult)*	260	40.85
35614	Colposcopy	180	59.80
35608	Cervical biopsy	180	59.85
35611	Cervical polyp removal	120	59.85
35615	Vulva biopsy + 35614 (59.50)	120	65.90
31230	Excision vulva lesion	300	142.85
35620	Pipelle endometrial biopsy	120	49.95
55068	Pelvic ultrasound/ TV scan	100	32.20

Non Rebate Items

	Fee
Script Refills	20

I …….have read the above information regarding my gynaecological care and I understand the fee structure and that payments are my responsibility.

Patient's Signature: ……. Date:……..

Consent to collect and disclose patient information:

We require your consent to collect personal information about you, please read the information in this consent form carefully. This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways and in accordance with the Privacy Act 1988:

1. Administrative purposes and quality assurance in running our medical practice.

2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.

3. Disclosure to others involved in your health care,
    1) Including treating doctors and specialists outside this medical practice. (This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals).
    2) Where State or Federal Law requires i.e. notifiable diseases
    3) Our practice doctor's medical indemnity organization if obligated to do so.

Please sign where indicated below that you have acknowledged the following statements:
I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information which can be found on the Wellbeing of Women website or upon request.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

Do you consent to having medical results that have been requested by this practice sent to you via the following formats?

Phone☐ Email☐ Mail☐ Neither☐ (Please Tick)

Name: ……..... Signature: .....…… Date: ……

TRANSVAGINAL ULTRASOUND CONSENT

Trans vaginal ultrasound is an examination of the female pelvis and urogenital tract (kidneys and bladder). It takes approximately 15 minutes to perform. It helps to see if there is any abnormality in your uterus, cervix, endometrium (lining of the uterus), fallopian tubes, ovaries, bladder and pelvic cavity. It differs from the abdominal ultrasound as it looks at the pelvic organs from inside the vagina. It is done if you have symptoms of pelvic pain, abnormal bleeding, fibroids, polyps, ovarian cysts or tumours, infertility or assessment of early pregnancy. There are no known risks with performing a trans vaginal ultrasound. It is a technique that uses sound waves to obtain pictures and there is no radiation used.

The Specialist **may** like to perform a trans vaginal ultrasound in her rooms at your visit to aid the diagnosis / treatment plan.

Do you consent to having a trans vaginal ultrasound? Yes☐ No☐ (Please Tick)

Name: ……..... Signature: .....…… Date: ……