RESPIRATORY SLEEP DISORDER CENTRE (RSDC) PATIENT REGISTRATION FORM

PATIENT DETAILS

Title: □Dr □Mr □Mrs □Ms □Miss □Other:

First Name: Last Name:
Preferred Name: Date of Birth:
Home Phone: Mobile Number:
Address:
Postal Address:
Email Address:

Next of Kin:
(Name, Address and Telephone Number)

Relationship to Patient

Emergency Contact
(If different to Next of Kin)

INSURANCE INFORMATION

Medicare Number: Your Ref no: Expiry Date:
Pension Card Number:
DVA Number:
Name of Private Health Fund: Member Number:

INFORMATION ABOUT FEES

Payment in full is required on the day of the consultation.
TAC and Workcover claims must be paid in full and a receipt will be issued for the patients to reimburse it from responsible party.

Dr Aminazad does not bulk bill at his Private Rooms. He does attend the bulk bill clinics at Angliss, Box Hill and Maroondah Hospitals.

PAYMENT AND CANCELLATION POLICY

We will attempt to contact you prior to your appointment to confirm your booking, if we cannot contact you, we will assume you are not attending and cancel the booking. In the event an appointment is not attended after confirmation or cancelled with less than 48 hours' notice, a 50 dollar cancellation fee will be charged.
Accounts are payable on the day, if the account isn't settled on the day of consultation a fee will be added to the invoice.

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REGULAR GP DETAILS

Name: Clinic Name:

REFERRALS

We require your referral letter to be sent to us prior to your appointment. If you have a CT scan of your lungs (CDs or films) please bring them to the appointment.
Specialist referrals are valid for 3 months and GP to specialist referrals are valid for 12 months. You are recommended to have a referral from your GP to last for one year.

There is out of pocket of $250 for Cardio Pulmonary Exercise Test and $120 out of pocket for Home-Based Sleep Study for all patients.

I have read and accept that I am responsible for having a valid referral and I agree to pay any associated fees.

Signature: Date: