

**Patient Information and Financial Consent**

Given Name \_\_\_\_\_

Surname \_\_\_\_\_

Address \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone: Mobile \_\_\_\_\_

Email Address \_\_\_\_\_

Partners Name \_\_\_\_\_

Partner's Mobile \_\_\_\_\_

GP's name \_\_\_\_\_

GP Practice \_\_\_\_\_

Medicare Number \_\_\_\_\_

Ref No \_\_\_\_\_

Medicare Expiry Date \_\_\_\_\_

Health Fund \_\_\_\_\_

Membership Number \_\_\_\_\_

Length of Health Fund Membership with Full Maternity Cover (approx.) \_\_\_\_\_

\*\*Is this a Student or Oversea Visitors Health Fund Membership  
**(Please circle if applicable)\*\***

I acknowledge that I have received a copy of and understand the fees and charges made by Dr Suzanne Meharry. I understand that this is an estimation and these costs may be subject to change. I understand that I will be responsible for the outstanding balance of the delivery account.

I understand that other Health Care Professionals may be involved in my care and that this estimation of fees does not cover their costs.

I give permission for my medical records to be shared with other Health Professionals involved in my antenatal care and/or to obtain my medical records from any other hospital or doctor that has treated me in the past.

Signed \_\_\_\_\_

Date \_\_\_\_\_