DR RUCHI SINGH MBBS, MD, MRCOG, FRANZCOG
UROGYNAECOLOGIST & PELVIC RECONSTRUCTIVE SURGEON

NEW PATIENT REGISTRATION

TITLE: MRS MS MISS DR PROF

FULL NAME: ______________________________

DATE OF BIRTH: ____________ AGE: ____________

ADDRESS: ______________________________

TELEPHONE: HOME: ______________________________

WORK: ______________________________

MOBILE: ______________________________

EMAIL: ______________________________

OCCUPATION: ______________________________

MEDICARE NUMBER: ______________________________

NUMBER NEXT TO NAME ON MEDICARE CARD: ____________ EXPIRY DATE: ____________

DEPT. VETERAN AFFAIRS NUMBER: ____________ DOES IT COVER MEDICAL EXPENSES?: Y? N?

GOVT CONCESSION CARD NUMBER: ____________ EXPIRY DATE: ____________

DO YOU HAVE PRIVATE HEALTH INSURANCE HOSPITAL COVER? Y? N?

HEALTH FUND NAME: ____________ MEMBER NUMBER: ____________

HAVE YOU SERVED THE 1 YEAR WAITING PERIOD WITH YOUR HEALTH FUND?: Y N

NEXT OF KIN: ______________________________

RELATIONSHIP: ______________________________

CONTACT PHONE NUMBER/s: ____________ ____________

REGULAR GP NAME (IF DIFFERENT FROM REFERRING DOCTOR): ____________

CLINIC NAME & ADDRESS: ______________________________

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PHONE: ____________

HEALTH QUESTIONNAIRE

FULL NAME: ____

AGE: ____

REASON FOR YOUR VISIT: ____

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____

OTHER CURRENT MEDICAL COMPLAINTS/DISORDERS:____

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PAST MEDICAL HISTORY:____

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PREVIOUS MAJOR SURGERIES:____

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____

CURRENT MEDICATIONS/HERBAL MEDICINES (unless listed on referral):____

____

DRUG ALLERGIES/REACTIONS:____

____

OBSTETRIC HISTORY (pregnancies/births):____

DO YOU SMOKE? (If so how many per day): ____

DO YOU CONSUME ALCOHOL? (If so how many standard drinks per day/week): _______________________________

DO YOU CONSUME CAFFEINE (Tea/Coffee)? (If so, what and how many per day): _____________________________

HOW MANY GLASSES OF WATER DO YOU CONSUME PER DAY?: ____

This practice is committed to ensuring high level privacy for personal health information collected, used and disclosed in the course of effective patient care. During this process, both collection and sharing of information with other treating practitioners may be necessary. Should your health information be required for other purposes, your further consent will be required.

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FEE SCHEDULE

- **New Consultation:** $180 (Medicare Rebate: $72.75)
- **Review Consultation:** $100 (Medicare Rebate: $36.55)
- **Pensioners/Health Care Card Holders:**
  - **New Consultation:** $170 (Medicare Rebate: $72.75)
  - **Review Consultation:** $95(Medicare Rebate: $36.55)
- **Department of Veterans Affairs:** All billed directly to DVA
- **Vaginal Ring Pessaries**: $70.00 each (No rebate from Medicare/Health Insurance)
- **Vaginal Dilators/Kits:** $70.00 each (No rebate from Medicare or Health Insurance)
- **Urodynamic Studies & Cystoscopy:** Healthfunds billed directly. No out of pocket for patients with Hospital cover unless patient has an agreed excess to pay to Hospital on day of Admission.
- **Uroflow Studies:** $56 (Medicare Rebate: $23.45) plus review consultation fee
- **Insertion of IUD:** $150 (Medicare Rebate: $45.55) plus review consultation fee
- **Biopsies (in rooms):** As advised by Dr Singh
- **Surgery:** In the event that you require admission to hospital for surgery, after consultation with Dr Singh, you will be sent a quote for the private surgical fee that Dr Singh charges (which is dependent on the surgery to be performed). This fee cannot be claimed through Medicare or Healthfunds. It is usually paid prior to surgery, however a payment plan can be arranged after a deposit is made pre-operatively. This fee covers your post-operative appointments up to 6 months. After your surgery, we send your hospital account to your healthfund and we do not charge above what the healthfund or medicare will pay. In addition, you may also receive an account post operatively from the assistant surgeon and anaesthetist. Some surgical devices used during surgery can also generate a fee which is payable to the Hospital.
- **Post-Operative Consultations:** Appointments bulk billed up to 6 months post operatively

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FINANCIAL CONSENT

The policy of this practice is payment on the day of consultation. If payment presents a difficulty, please speak with the secretary before your consultation. If you do not have private health insurance (hospital cover), please be aware that procedures requiring admission to Hospital will generate significant out of pocket costs if you choose to go ahead with the procedure. I understand and agree to the above billing procedures. I acknowledge that if an account is overdue, Dr Singh reserves the right to refer the account to a third party. I agree to meet all reasonable costs incurred by Dr Singh, in employing the third party to collect any overdue accounts.

Full Name: ______________________________ Signature: _________________________ Date: _____________