



BURTON Street Family Practice

New Motor Vehicle Accident Form

Surname:	Given Names:	Date of Birth: / /
Address:		Postcode:
Home No:	Work No:	
Mobile No:	Email:	
Date of Accident: / /	Claim No (if known):	

By signing below, you (as a patient/parent/guardian) are consenting to the following:

- I may be responsible for payment at the time of my consultation until such time as my claim has been approved by the Insurance Commission of Western Australia, and a claim number is obtained.
- If the claim is rejected, I agree to pay for all medical expenses incurred within 30 days of rejection.
- I give permission to Burton Street Family Practice to release information regarding my condition and treatment to the Insurance Commission of Western Australia and other relevant health professionals related to my treatment and claim.
- If I see the doctor for an insurance related matter **and** a Medicare claimable matter, and the insurance claim is rejected later, I understand I will **not** be able to receive a rebate from Medicare for the rejected insurance claim.
- I am aware that I may be charged for missed appointments unless I give 24 hours' notice.

Signature: _____ Date: _____

Name: _____
(Please print name if parent/guardian signing)