Burton Street Family Practice

New Workers Compensation Form

Surname:	Given Names:	Date of Birth: / /
Address:		Postcode:
Home No:	Work No:	
Mobile No:	Email:	
Date of Accident: / /	Claim No (if known):	
EMPLOYER DETAILS		
Employer Name:		
Contact Person:		
Employer Address:		Postcode:
Phone No:	Fax No:	
Email:		

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, 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 company 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)