PATIENT INFORMATION FOR
BILLING OF NON-REBATABLE TESTS

FOR-SS-063

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Billing of Non-Medicare Rebatable Tests

The pathology request that you have been given by your medical practitioner includes tests which are either partially or not fully covered by Medicare.

The full cost of testing must be covered by the patient or, in the case of children, their family. Austin Health Pathology requires your consent to proceed with this testing with the full understanding that you will accept responsibility for payment. Please discuss with your medical practitioner if you do not wish to proceed with the test.

If your test is referred to a laboratory other than Austin Pathology, you may receive an invoice from the referred pathology service. The referred laboratory will require your written agreement of payment before performing your test.

Patient Name: _____

Test Name: _____

The cost of the test requested by your doctor is estimated at A$ _____

I hereby agree to accept responsibility for full payment of non-Medicare rebatable tests performed by Austin Health Pathology or an external laboratory.

Patient/ Parent Signature _____

Date ___/___/___

For further information, please call Austin Pathology Accounts on 9496 3100

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