

PATIENT REGISTRATION & CONSENT FORM

Full Name: _____ **Date of Birth:** ___ / ___ / _____

Residential Address: _____

Mobile: _____ **Home Phone:** _____ **Email:** _____

GP Name: _____ **Medicare Number:** _____ **Reference No.:** ____

Private Health Fund: _____ **Member No.:** _____ **DVA Number:** _____

Next of Kin Name: _____ **Phone:** _____ **Relationship:** _____

Terms & Conditions

1. I understand that **Dr Rudd Cardiology does not provide urgent or emergency cardiac care.**
2. If I experience **chest pain lasting more than 10 minutes**, I will **call 000 immediately** for an ambulance.
3. I understand that **Dr Rudd Cardiology provides cardiac services only** and that any **non-cardiac causes** or investigations related to my symptoms must be discussed with my **GP**.
4. I understand that my **GP is my primary point of contact** for any deterioration in my condition, and in emergencies I should **attend the nearest Emergency Department**.
5. I understand that **bulk-billed cardiac investigations** (Holter, ECG, Echo, and Stress Echo) are available to **eligible patients. private consultation fees apply** if not eligible .
6. I understand that **bulk-billed consultations** are limited and available only to **eligible patients**.
7. I understand that a **valid referral** is required to qualify for bulk billing and that it is **my responsibility** to provide this to Dr Rudd Cardiology **before my appointment**.
8. I understand that **private consultation fees apply** for patients seeking **second opinions** or **interpretation of cardiac investigations** not performed by Dr Rudd Cardiology.
9. I understand that an **administration fee** will apply if Dr Rudd Cardiology must **retrieve my investigation reports** that were not received prior to my appointment.
10. I understand that a **cancellation fee of AUD \$300** applies if I **cancel, reschedule, fail to attend, or arrive late** to my appointment **within 48 hours** of the scheduled time.
11. I understand that I must **arrive at least 15 minutes prior** to my appointment time.
12. I understand that the **Holter monitor must be returned by 9:00 AM** on the agreed return date.
 - A **late return fee of AUD \$300 per day** applies for any delay.
 - If I am unable to return it personally, I may arrange for a **family member, friend, or courier (e.g., Uber Parcel)** to deliver it before 9:00 AM.
13. In the event of an **overdue account**, I agree to be **liable for all costs incurred in full**, including **legal demand fees**.
14. **Overdue accounts** will be subject to **interest at 25% per annum**, calculated for the period the account remains unpaid.
15. I confirm that I have been **advised of consultation costs**, including those for **telehealth services**.
16. I have **read, understood, and agree** to abide by all the above terms and conditions.
17. I **consent to Dr Rudd Cardiology** obtaining and sharing information relevant to my medical condition as required for my care.

Full Name: _____ **Signature:** _____

Date: ___ / ___ / _____