NSW GOVERNMENT Health Pathology

creating better health & justice systems
www.pathology.health.nsw.gov.au

# CONSENT FOR PAYMENT OF NON-MBS TESTS

## Patient Details

MRN (If available)

Name DOB / /

Address

Post Code

Phone Email

### Requesting Practitioner

Name Provider Number

Address

Post Code

### Test Requested

| Test name | Price (Inc GST) |
|---|---|
| | |
| | |
| | |
| | |
| | |
| TOTAL | |

### Person/Institution Responsible for Payment

Name

Address

Post Code

Phone Email

I understand that the test requested is not covered by Medicare. I have been advised of the cost and understand that I will receive an invoice from NSW Health Pathology for this service, and I accept responsibility for the full payment of the fee for the test.

Date / / Signature

***For Office Use Only***

| | | |
|---|---|---|
| *Payment Received by* | *Collection Site* | *Receipt No.* |
| *Testing Location* | | |