ST VINCENT'S HOSPITAL MELBOURNE
A FACILITY OF ST. VINCENT'S HEALTH AUSTRALIA
RCPA The Royal College of Pathologists of Australasia
NATA
Accredited for compliance with NPAAC standards and ISO 15189
Accreditation No. 13786

MITOCHONDRIAL AND AUTOIMMUNE NEUROLOGICAL DISORDERS LABORATORY

5th Floor, Daly Wing, St Vincent's Hospital,
35 Victoria Pde, Fitzroy, Victoria, AUSTRALIA 3065
Tel (613)9231 3366 Fax (613)9231 3350

ilac-MRA NATA WORLD RECOGNISED ACCREDITATION

OUT OF POCKET COSTS
CONSENT FOR PAYMENT OF TESTING

Please be aware testing CANNOT be claimed through *Medicare or Private Health Insurance.*

Patient Name:……..……DOB:……..……
Address:……..……UR……..……...
Mitochondrial genetic test:..... Autoimmune Encephalitis test:……..……

The TOTAL COST of the test/s requested is: $..... + GST.

Invoicing - please choose by tick or cross and provide information for one of the following three options:

☐ **1. Health institution/department to be invoiced.**

(Do not invoice to Department of Clinical Neurosciences, St Vincent Hospital)
Please advise us of the FULL contact name and FULL address of the person/department or hospital and authorization purchase order number to whom the invoice for the testing should be sent to:

Name……..

Address……..

Telephone Number:…….....Email Address……..

Institution Authorisation or Purchase Order Number…….....

Signed:……..Date:……/……/…….

OR

☐ **2. Patient to be invoiced**

I (Name), …….....of (Address)……

Telephone Number…….....….Email Address…….....

consent to pay the total cost of the requested test(s) listed above.

Signed:……..Date:……/……/…….

Charge my Credit Card: Visa Mastercard

Card Holder Name:……..

Card No:……**CVV**……..**Expiry Date**:……

Card Holder Signature……Date:……/……/…….

OR

☐ **3. Please DO NOT proceed with testing**

Testing will not commence until this information has been received.

Please return via fax, email or post to
Dr. Rosetta Marotta
Fax: (+61) 3 9231 3350
Email: rosetta.marotta@svha.org.au