

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

CONSENT FOR PAYMENT OF GENETIC TESTING

DATE:

TO:

Address:

We have received a request for testing for the following genetic disorder(s):

For patient:

D.O.B.:

UR and SVR No:.....

The TOTAL COST of the test(s) requested is:...\$.....(Note: we are NOT able to bulk bill)

Invoicing - please choose and provide information for one of the following three options:

	1. Health institution/department to be invoice	d. (Please be aware the departmen	t or hospital in
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which the test laboratory is located is not responsible for payment on the patient's behalf).

Please advise us of the FULL contact name and FULL address of the person/department to whom the invoice for the testing should be sent to:

Name.....

Address.....

OR

2. Patient to be invoiced (please be aware testing CANNOT be claimed through Medicare or			
Private Health Insurance). Please provide the patient's address and have them sign the consent below:			
I (Name),of (Address)			
consent to pay the total cost of the requested test(s) listed above.			
Signed: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 Address: 5th Floor Daly Wing, 35 Victoria Pde Fitzroy Vic 3065

This letter is confidential and intended for the addressee and contains legally privileged information and may be confidential or otherwise protected from disclosure in the public interest lf you are not the intended recipient, or employee or agent responsible for delivering the letter and its attachments to the intended recipient and you have received it in error please contact the laboratory and destroy the copy. The distribution, dissemination, copying or disclosure of the contents or its attachments are strictly prohibited. Document Name: Billing Consent Form Version 4 Prepared by Rosetta Marotta Date reviewed/ issued February 2017