



ST VINCENT'S
HOSPITAL
MELBOURNE

A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA



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



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 panel test:.....
The TOTAL COST of the test/s requested is: \$..... + GST (\$240+gst per mito variant/gene or autoimmune panel per sample)
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 Mastecard

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

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 if 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
Prepared by Rosetta Marotta
Authorised by Professor Steve Collins

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