MITOCHONDRIAL AND AUTOIMMUNE NEUROLOGICAL DISORDERS LABORATORY

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35 Victoria Pde, Fitzroy, Victoria, AUSTRALIA 3065
Tel (613)9231 3366 Fax (613)9231 3350

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

ilac-MRA

NATA WORLD RECOGNISED ACCREDITATION

OUT OF POCKET COSTS
CONSENT FOR PAYMENT OF TESTING

Please be aware testing <u>CANNOT</u> 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 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