Fowler Simmons Radiology
100 Hutt Street
Adelaide SA 5000
T 08 8229 2100
F 08 8229 2111
ABN: 53 156 140 831
www.fsradiology.com.au

FINANCIAL CONSENT (WORKCOVER)

PATIENT DETAILS

Family Name					
Given Name					
Address					
Suburb		State		Postcode	
Date of Birth	/ /	Phone	( )		
Email	@				

EMPLOYER DETAILS

Company Name					
Contact Name					
Address					
Suburb		State		**Postcode**	
Phone	( )	Fax	( )		
Email	@				

CLAIM DETAILS

Insurer			
Claim Number			
Date of Injury			
Case Manager's Name			
Phone	( )	Fax	( )
Email	@		

DECLARATION BY PATIENT:

If your examination is related to a Workcover claim you must provide sufficient claim information on the day. If the claim is not approved or in dispute, without written confirmation, the account must be covered by the patient.

I agree to and accept financial responsibility for the cost of the procedures performed by Fowler Simmons Radiology. I understand and acknowledge that in the event that my employer or their insurer do not pay for the service(s) performed, it is my responsibility to cover the outstanding account.

I accept that Fowler Simmons Radiology may be required to exchange any relevant information (e.g. copy of radiology report, account enquiries) to your case manager.

Patient or Guardian's signature _____ Date / /

Patient or Guardian's name (Please Print) _____