**<<Name of Practice>>**

**Financial Consent Form**

After informed discussion with Dr

 *Name of Patient’s GP*

I, consent to Dr

 *Full name of patient Name of patient’s GP*

performing the following procedure(s) on me at <<name of practice>>:

**Procedure 1**: Item#

Estimated surgical fee: Product Cost:

**Procedure 2**: Item#

Estimated surgical fee: Product Cost:

I have received and read the patient information notes about the procedure(s) above. Any concerns or questions have been answered to my satisfaction.

I accept that payment of the surgical fee covers my doctor performing the procedure with every skill and care consistent with his/her extensive experience and training.

I understand that the above estimated costs relate to the proposed treatment/procedure and may change as a result of variations in the actual treatment provided.

I accept that surgery is subject to variations with individual patient healing responses, timeframes and other factors that are outside the control of the doctor.

I am aware that I may receive separate accounts from other service providers associated with my treatment, such as pathology.

I understand that if I require revision procedures, secondary to the above surgical procedure, I will be fully responsible for any further costs involved.

Name: Date of Birth:

 *Full Name of Patient*

Address:

Guardian’s Name [if applicable]:

Patient / Guardian’s Signature: Date:

Office Use [ ]