Client Information

Dr Tim Edwards-Hart
Clinical Psychologist
DPsych, BAppSci(Psych)(Hons), GradDipBehavSc, GDipAdolHlthWelf

for adolescents, young adults, & their families

www.edwardshart.com.au

410/1 Princess St
Kew, Vic 3101

T 03 9005 5425
F 03 9078 1413

Medicare Provider: 4491422B
ABN: 28 292 104 214

Client details

Name: ____________________
Given name(s)

____
Preferred name

Family name: ____________________
Family name

Date of birth: ☐☐ ☐☐ ☐☐☐☐
Day Month Year

Parent/Guardian: (if under 18 years)

1. ____________________ Name of Parent/Guardian 1 | ____________ Phone | ____________ Relationship

2. ____________________ Name of Parent/Guardian 2 | ____________ Phone | ____________ Relationship

Client contact detail

Phone: ____________ Mobile | ____________ Home | ____________ Other (if required)

Email: ____________________
Preferred email address

Address: ____________________
Address line 1

____
Address line 2

____________ Town/Suburb | ____________ State | ☐☐☐☐ Postcode

Emergency contact: ____________ Name | ____________ Phone | ____________ Relationship

Appointment reminder preference: ❑ Email ❑ SMS ❑ Both ❑ None
This practice sends automated appointment reminders by email and SMS. If no preference is recorded, you will receive both.

Person responsible for account: ❑ Client ❑ Other ____________________
Given name Family name

Medicare details

I request and authorise HealthKit Pty Ltd to enable online Medicare rebate claiming by registering and storing the following Medicare information:

Card: ☐☐☐☐ ☐☐☐☐☐ ☐ **IRN:** ☐ **Valid to:** ☐☐ ☐☐☐☐
Medicare number | IRN is digit beside your name | Month | Year

[Optional] Low Income Health Care Card concession

Card: CRN ☐☐☐ ☐☐☐ ☐☐☐☐ **Expires:** ☐☐ ☐☐ ☐☐☐☐
Low Income Health Care Card number | Day | Month | Year

How did you hear about our service?

❑ GP/Physician ❑ Family/Friend ❑ School ❑ HealthDirect
❑ Find-a-Psychologist ❑ HeathKit ❑ Internet search (Google, Bing, etc)

❑ Other ____________________ ❑ Other ____________________

Have you visited our website www.edwardshart.com.au? ❑ Yes

If yes, did you: ❑ Visit before requesting an appointment?
❑ After booking, but before attending, an appointment?

Payments Authority

1. Practice Details

Dr Tim Edwards-Hart
410/1 Princess Street, Kew Vic 3101
office@edwardshart.com.au

ABN: 28 292 104 214
Phone: 03 9005 5425
Fax: 03 9078 1413

2. Client Name and Date of Birth

Given name ______ Family name ______ Day Month Year

3. Account Payer ❑ Client (go to next section) ❑ Other (complete this section)

Complete the remainder of this section only if someone other than the client is responsible for the account

Payer name: (if not the client) Given name ______ Family name ______

Address: Street ______

Town/Suburb ______ State ______ Postcode

Phone: Mobile ______ **Email:** To receive invoices via email, please include your email ______

Account Payer birthdate & Medicare details

Account Payer date of birth & Medicare number are required if claiming Medicare rebates

I request and authorise HealthKit Pty Ltd to enable online Medicare rebate claiming by registering and storing the following information:

Date of Birth: Account Payer Day Month Year

Card: Account Payer Medicare number **IRN:** IRN is digit beside your name **Valid to:** Month Year

4. Credit/Debit Card Payment Authority

I request and authorise HealthKit Pty Ltd (ABN 62 131 908 597) to debit funds from the nominated credit/debit card account identified below in accordance with this Payments Authority and the terms and conditions set out in the Credit/Debit Card Authority Service Agreement. I authorise HealthKit to debit funds from my credit/debit card identified below for appointments, products or services provided through this Practice (ABN 28 292 104 214).
I acknowledge that HealthKit Pty Ltd may appear on my statement.

Name on card: ______ ❑ MasterCard ❑ Visa ❑ AmEx

Card number: MasterCard or Visa number

or American Express number

Expiry: Month Year **Signature:** ______ Signature of Card Holder

5. [Optional] Bank details

If Medicare already has these details, or you are not claiming a Medicare rebate, you can leave this section blank.

I would like my Medicare rebates to be paid directly into the following account:

Bank Acc Name: ______ Name of Account Holder(s)

BSB: 6 digits **Account #:** Up to 9 digits

6. Signature

By signing this Payments Authority, I declare that the information on this form is correct. I acknowledge that I have read and understood the terms and conditions contained in this Payments Authority and the Credit/Debit Card Authority Service Agreement, and I agree to be bound by them.

Signature: ______ Signature of Account Payer **Date:** Day Month Year