Agreement to pay

SA PATHOLOGY

Enquiries 8222 3000

Patient Details

Name DOB / /

Address

Post Code

Referring Practitioner

Name Provider Number

Address

Post Code

Tests Requested

Test name	Price (inc GST)
TOTAL	

Person/Institution Responsible for Payment

Name

Address

Post Code

I understand that the test requested is not covered by Medicare. I have been advised of the cost and understand that I will receive an invoice from SA Pathology for this service, and I accept responsibility for the full payment of the fee for the test.

Date / / Signature