Agreement to Pay Form

A completed Payment Consent form must accompany all requests where:

- Testing is not covered by the Medicare Benefits Schedule (MBS)
- Patient does not meet MBS criteria
- Patient is not registered with Medicare.

Test charges for WA Health Service Providers are in accordance with the service level agreements.

Patient Details

Surname	DOB
Given Name/s	
Address	State
	Post Code
Phone	PathWest Order
Email	

Requesting Clinician

Name	Provider No.
Address	State
	Post Code
Referring Laboratory	Referring Sample No

Test/s Requested	**Price (ex GST)**
TOTAL $AUD	

Person/Institution Responsible for Payment

Name	
Address	State
	Post Code
Phone	
Email	

I understand that the testing requested is not covered by Medicare. I have been advised of the cost and understand that I will receive an invoice from PathWest Laboratory Medicine WA for this service and I accept responsibility for the full payment of the fee for the test.

Date Signature

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