SOUTH LAKE
FAMILY PRACTICE

Dear: _____

Details of the telehealth consultation to be claimed with Medicare:

Patient Name: _____

Item Number: _____

Benefit Amount: _____

Date and Time of consultation: _____

Health Professional Name: _____

If you _____ agree to the assignment of the Medicare benefit directly to the health professional (Bulk Billed), Please reply to the letter.

I AGREE / DISAGREE to the assignment of the Medicare benefit directly to the health professional.

Patient Verbally agrees / Email

Patients signature: _____

Patient parent / guardian signature: _____

Date: _____ Time: _____