APPLICATION FOR A REVIEW OF FEES
Please complete this form and return
to your clinician at your next appointment

Client UR No:

office use only

Client details

Name: _____

Address Line 1: _____

Address Line 2: _____

Suburb: _____ Post Code: _____

Telephone/Contact Number: _____

I wish to make an application for fee review.

I have read the Department of Health information (Information About Fees Policy) explaining how fees are charged and reviewed. how and issues to be taken into consideration to reduce or waive fees. I have circled the reason/s for this application on the Income Self-Declaration Form.

I believe that my circumstances warrant a:
Please tick waiver or fee reduction

☐ Fee reduction (I can pay _____ per hour/visit)

☐ Waiver (no charge)

Sign: _____ Date: _____
Client's Signature or if unable to sign, authorised representative

If signing on behalf of the client, please provide your full name and relationship to the client:

Name: _____Relationship to client: _____

Office Use Only:
Fee waiver/reduction approved/not approved for period from / / to / /

Clinician Name: _____ Date: _____

Branch Manager Name: _____

Signed: _____ Date: _____