Weight Loss Provider Registration Application Form

1. Personal Details

Title: Surname:

Given Name & Middle initial:

Postal address:

Suburb Postcode:

Date of Birth: / / Country of Birth:

Are you an Australian Citizen?

Yes No

No - If No, are you a permanent resident?

Yes

Modalities treated:

I am currently a member of the following relevant professional associations:

Organisation:

Membership level:

Member number and commencement date: / /

Organisation:

Membership level:

Member number and commencement date: / /

Organisation:

Membership level:

Member number and commencement date: / /

Please attach documents issued by association(s) confirming your membership number and starting date of membership.

Has membership with any professional body or association been cancelled, suspended or withdrawn for any reason associated with the provision of any service to the patient?

Yes (provide details and attach to this form)

No

2. Practice Details

2.1 Practice basis Full time OR Part time

Principle Practice/Clinic address:

Suburb Postcode:

Commencement date: / /

Phone number: Fax number:

Details of other Practitioners working from the same practice.

Name(s):

Address(s):

Modalities treated:

(For fund records only, providers must apply for their own registration)

2.2 Practice basis Full time OR Part time

Other Practice/Clinic address:

Suburb Postcode:

Commencement date: / /

Phone number: Fax number:

Details of other Practitioners working from the same practice.

Name(s):

Address(s):

Modalities treated:

(For fund records only, providers must apply for their own registration)

Are you registered under a company name for any of these practices? Yes No

If yes, please provide:

Company name:

Trading name:

ACN number:

3. Educational Qualifications

Please provide the following details and attach copies of academic transcripts showing subjects studied and certified copies of awards attained.

Year of award	Title of award	Course duration (hrs)	Institution name and locality, where studies were undertaken

I have been continuously practising _____ for _____ years.

4. Provider Guidelines

1. All accounts/receipts must clearly show the following:
   - The name of the service provider. Where the provider is part of a group of providers, the account/receipt must clearly show the name of the provider who provided the service.
   - The address of the service provider/practice.
   - The date on which the account/receipt was issued.
   - The name of the patient and the date of each service provided to them, and a breakdown of the individual cost of each component of the service.
   - A description of the service provided.
   - Details of any payment made, and any outstanding balance.
2. HCI recognised providers may not allow any locum, colleague or employee to issue receipts for treatment in the name of the HCI registered provider other than for treatment or services actually performed by that registered provider.
3. Benefits are not payable for treatment/services provided by therapy/clinic assistants or students of the profession. When an assistant/student administers treatment, then the account/receipt must clearly itemise such treatment separately.
4. All duplicate accounts/receipts must be endorsed as 'duplicate'.
5. All accounts/receipts should be on printed stationery. If they are produced electronically the provider of that service or their representative should sign them at the time of issue.
6. The fund name should not be used for any advertising, or promotional use without prior written permission.

5. Acknowledgment / Undertaking

I declare that the above details are true and correct. I agree to abide by HCI guidelines listed herein and I understand that HCI reserves the right to determine further requirements from providers from time to time in order to establish provider recognition.

I acknowledge that where HCI provider recognition is granted that it can be withdrawn or suspended for breach of professional misconduct without question or prior notice. I accept that it will be necessary to follow the guidelines provided to retain this recognition.

_____ of _____ ___ / ___ / ____

(Signature) (Date)