**Clinical Trials Financial Consent Form**

I acknowledge that a member of the <insert> team has explained to me and I understand, that by participating in a clinical trial I may incur out of pocket expenses that are not covered by my health insurance, as would be the case if I was receiving standard of care treatment at Epworth HealthCare.

Examples of out of pocket expenses that may be incurred include health fund excesses, Epworth HealthCare chair or bed fees and fees charged by third party providers which are not covered by Medicare and may include pathology, pharmacy and imaging service fees. Epworth HealthCare does not profit financially from those out of pocket fees.

By signing this consent I acknowledge that I am liable for out of pocket expenses that are incurred as a result of my participation in a clinical trial.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Patient Name

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Senior member of the research team whom provided the explanation regarding financial implications relating to participation in a clinical trial.