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Patient Details
(To be completed by the patient)

General Information

Surname: _____ First name/s: _____

Initials: _____ Title: _____ Maiden/previous names: _____

I.D. number: _____ Gender: M / F Date of birth: _____/_____/_____

Telephone: (H): _____ (W): _____ Cell: _____

Postal address: _____ Code: _____

Residential address: _____ Code: _____

E-mail: _____ Home language: _____

Marital status: _____ Referred doctor: _____

Occupation: _____ Name of employer: _____

Medical Aid Details

Medical aid name: _____ Medical aid plan: _____

Medical aid number: _____ Main member: _____

Main member's beneficiary code: _____ Your beneficiary code: _____

Person Responsible for Account / Main Member of Medical Aid

Surname: _____ Full name(s): _____ Title: _____

I.D. No: _____ Email: _____

Telephone: (H): _____ (W): _____ Cell: _____

Postal address: _____ Code: _____

Residential address: _____ Code: _____

Patient Terms and Conditions

Please read this agreement carefully and sign if you fully understand and agree to the terms and conditions

Information Consent

I understand that I have the right to ask the attending doctor(s) and / or researcher(s) to explain to me the testing procedure(s) before agreeing to any testing procedure, including the following:

- The aim(s) and purpose(s) of the specific test / procedure.
- The protocols to be followed during the specific test / procedure.
- The benefits and risks associated with the specific test / procedure.
- How and when re-testing may occur.
- That I have the right to obtain a second opinion at any time.

Privacy of Medical Information

I understand that this practice has reasonable security measures in place to protect the unauthorised disclosure of my patient information, and that I may revoke my authorisation in writing at any time.
My patient information may be disclosed by this practice upon special request by law enforcement agency, subpoena, court order, or the law.

Practice Fees and Conditions:

- Initial Consultation: R 1 315.00
- Follow-up Consultation: R 950.00

The above charges are not inclusive of the procedure that may be performed and prescribed medication.
These prices are inclusive of VAT and will be subject to change.

Payment of Medical Costs

I acknowledge that:

- I am informed that this practice is not contracted to medical aid.
- I am fully responsible to settle the payment immediately following my appointment / testing procedure(s).
- Please note that payment is strictly immediately following your consultation. Payment methods include credit card or Electronic Funds Transfer at one of our devices.

General

I confirm that:

- I freely chose this practice to consult with.
- I am aware that the attending doctor(s) and / or researcher(s) is generally only available during office hours and consulting hours.
- I am obliged to inform the practice of changes regarding my personal, medical and / or financial information.
- I understand that the attending doctor(s) and / or researcher(s) has the right to change his / her opinion on a testing decision at any time.
- I have an opportunity to review these terms and conditions.
- This form reflects my wishes.
- I have read and understood each of the terms and conditions, as contained in this agreement.
- I have a right to inspect these terms and conditions and / or request a copy.
- I voluntarily sign these terms and conditions.

By signing this document, you are legally committing yourself to the terms and conditions contained herein.

PATIENT SIGNATURE: _____ DATE: _____