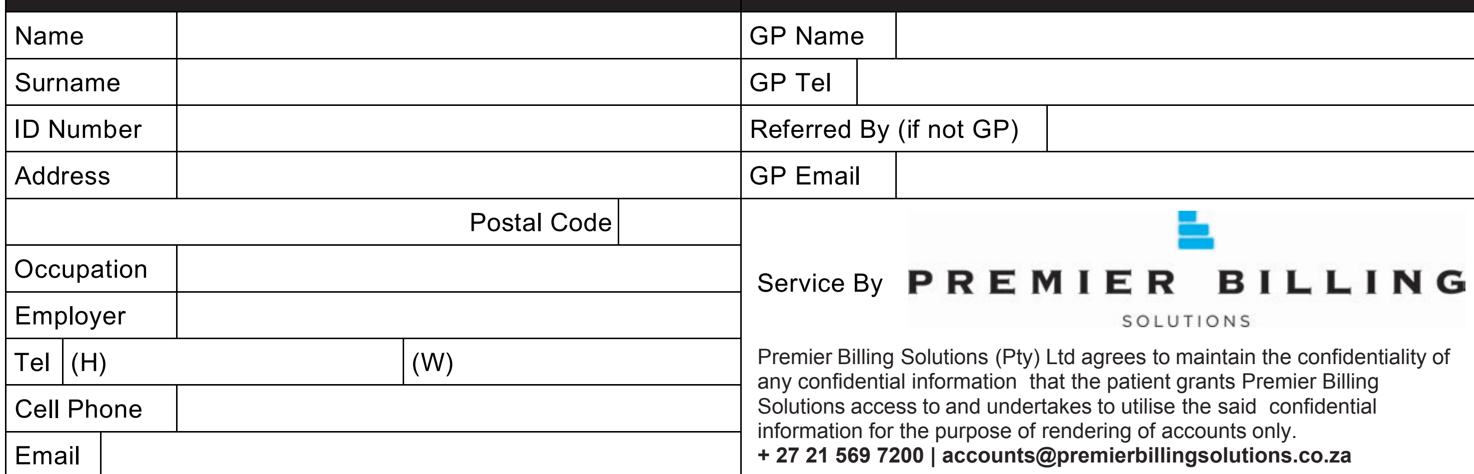
DRS WEBB, GOVENDER, MOOLMAN, JEHLE, DEWAR & SALUKAZANA INC
Trading as Cape Urology

PR. NO. 0799246
Reg. No. 2018/489859/21

Drs Govender, Moolman and Dewar Practice Contact No: 021 683 1974	Drs Webb and Salukazana Practice Contact No: 021 761 7047	Drs Jehle, Moore and Oppel Practice Contact No: 021 569 3662

PATIENT DETAILS			
Surname		Occupation	
First Names		Work Address	
Title		Postal Code	
Date of Birth		Tel (H)	(W)
ID Number		Cell Phone	
Home Address		Email	
Postal Code		Patient Dependent Code	

MEDICAL AID DETAILS		NEXT OF KIN	
Gap Cover	Yes No	Full Name	
Main Member Surname		Relationship to Patient	
Main Member First Names		Address	
Main Member ID Number		Postal Code	
Medical Scheme		Tel (H)	(W)
Medical Scheme Plan		Cell Phone	
Medical Scheme Number		Email	



PERSON RESPONSIBLE FOR THE ACCOUNT		GENERAL PRACTITIONER	
Name		GP Name	
Surname		GP Tel	
ID Number		Referred By (if not GP)	
Address		GP Email	
Postal Code		Service By PREMIER BILLING SOLUTIONS	
Occupation			
Employer			
Tel (H)	(W)		
Cell Phone			
Email			

Premier Billing Solutions (Pty) Ltd agrees to maintain the confidentiality of any confidential information that the patient grants Premier Billing Solutions access to and undertakes to utilise the said confidential information for the purpose of rendering of accounts only.
+ 27 21 569 7200 | accounts@premierbillingsolutions.co.za

I, the undersigned, agree as follows:

1. I am personally liable for medical services rendered by the doctor to me and/or to any person of whom I am the parent or the legal guardian;
2. To pay promptly the account of the doctor in accordance with the tariff of charges prevailing in the doctor's Practice, or as agreed with me, and in the manner in which the parties have agreed;
3. To settle the doctor's account on time and in full, as agreed, irrespective of contracts/ agreements/ arrangements I may have with any medical scheme or any third party;
4. Should the doctor institute legal action against me for recovery of any outstanding debts, to pay all legal costs, including attorney and own client costs, collection fees and tracing fees;
5. Should the doctor hand an outstanding account over to a debt collection company, that debt collection company is the sole point of contact, and I will only correspond with that company in respect of the outstanding account.
6. I acknowledge that, in accordance with the provisions of Section 53(1) of the Health Professions Act of 1974 and Section 6(c) of the National Health Act 61 of 2003, the costs associated with all medical services rendered by the doctor, treatment and/or procedures have been discussed and were fully explained to me, to the extent required in law and professional ethics.

I hereby choose my above address as my *domicilium citandi et executandi* for all purposes under this agreement. I HAVE READ, UNDERSTAND AND AGREE TO THE CONDITIONS MENTIONED ABOVE. I CONFIRM THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT.

Full Name:			
Signed:		Date:	

PATIENT TERMS AND CONDITIONS

Please read this agreement carefully, and sign if you fully AGREE & UNDERSTAND these terms & conditions.

INFORMED CONSENT

I understand that I have the right to ask my doctor to explain and disclose medical information to me before I agree to a medical procedure or treatment, including the following:

- different treatment options available to me;
- common and severe side effects of specific treatment options;
- the benefits, risks, costs, and consequences associated with each option;
- details of the diagnosis and prognosis, and the likely prognosis if the condition is left untreated;
- any uncertainties regarding the diagnosis;
- how and when my condition and any side effects will be monitored or re-assessed;
- the name of the doctor who will have overall responsibility for the treatment;
- that I have the right to seek a second opinion at any time;
- And I confirm that this information has been provided to me.

GENERIC MEDICINE

I understand and acknowledge that my Medical Scheme may insist that I substitute medicine that appears on my prescription with its generic equivalent. It is within my doctor's sole discretion and clinical judgement whether or not to allow for the generic substitution of my medicine and no substitution may take place where the doctor has written 'no generic substitution' on my prescription.

DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize:

- the use and disclosure of my medical information to any relevant specialist as my primary doctor may see fit;
- that a copy of my medical record will be kept by my doctor on file. I have been made aware that all consultations and interaction with the doctor are subject to electronic storage and copies will be stored in a secure server as part of practice note-keeping for the personal use of the doctor;
- the disclosure of relevant medical information to my Medical Scheme - will typically include diagnoses, ICD10 codes and procedural codes;
- the practice to have access to my hospital records, radiology & laboratory results.

PRIVACY OF MEDICAL INFORMATION

I understand that this practice has implemented reasonable security measures to guard against the unauthorized disclosure of my patient information and that I may revoke my authorization in writing at any time.

My patient information may be disclosed by this practice, without my consent, in response to a specific request by a law enforcement agency, subpoena, court order, or as required by law.

PAYMENT OF MEDICAL COSTS

I acknowledge that:

- I have been informed that this practice does not necessarily charge the rates that my Medical Scheme may have decided upon;
- My Medical Scheme may or may not cover all the fees charged by this practice. Should there be a shortfall, I remain personally liable for payment of that shortfall;
- I undertake to settle all fees incurred through elective or emergency consultation, deliveries, procedures, or care otherwise provided irrespective of my agreement with my medical Scheme. If there is any delay or dispute (by my insurer or other) regarding payment, I undertake to settle the account personally within 30 days of services rendered;
- I am fully responsible for payment and should I not pay timeously, I will be liable for debt recovery & legal costs;
- I am also aware that there will be annual increases in practice fees for all consultations, deliveries and procedures, and that unless a formal quotation for a specific procedure is accepted in writing by both client and provider, these cost-increases will apply to all patients (usually effective 1 January of each year).

INTEREST ON OVERDUE ACCOUNTS

I am aware that 2% interest and administrative costs will be charged per month (after 60 days) for all overdue accounts and that legal steps will be taken by the practice with any additional costs incurred to be added to my account.

MEDICAL CERTIFICATES ('SICK NOTES')

I hereby acknowledge that I understand that although I am entitled to ask for a medical certificate from my doctor, he/she is under no obligation to issue such a certificate. My diagnosis will only be disclosed on the certificate provided I have given my written consent, and the decision who I want to show the certificate to is at my sole decision.

PRE-AUTHORISATION

I am fully aware that if a treatment requires hospitalization, I am personally responsible for ensuring that pre-authorization is obtained from my medical scheme BEFORE I undergo the procedure. If my medical scheme declines payment for any reason whatsoever, I remain responsible for making full payment for the services rendered to me.

My Medical Scheme may request information or formal motivation from my doctor before authorising the procedure. I acknowledge that I am responsible to pay for the costs of such motivation or information supplied to my medical scheme.

ICD-10 DIAGNOSTIC CODING

Regulation 5(1) of the Medical Schemes Act (published in the Government Gazette NO 20566 on October 20th,1999) states that an account to the Medical Scheme must contain the relevant diagnosis. This must be submitted as an ICD-10 diagnostic code (number allocated to your diagnosis by the international classification of diseases) and may be used in referral letters, requests for special investigations and prescriptions. Failure to submit the correct codes might lead to a claim incorrectly paid or not paid at all.

MEDICAL RESEARCH

I understand that diagnostic and procedural information (as well as any related photographs) related to my treatment may be utilized for practice statistical, research and/ or teaching purposes. All such information will be dissociated from patient information and informed consent will be obtained by the practice if any of my information is required for clinical trials or research. I have the right to decline the taking of photography or the use of any images by the practice.

CONSENT TO PROCESS PERSONAL INFORMATION

I acknowledge that my personal information needs to be processed by the practice and therefore grant the following consent:

I acknowledge and accept that the medical practice will during the course of rendering services to me, collect and have access to my personal information, including information relating to my race, gender, sex, pregnancy, marital status, national, ethnic, or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language, identifying number, symbol, e-mail address, physical address, telephone number, location information, online identifier and my biometric information.

I grant my express consent for the practice to collect and process this information for the purpose of rendering services to me as well as processing claims with medical schemes or insurance funders.

Administrative staff employed in the practice may be granted access to my personal information contained in my health record, including any clinical notes, in order to process claims to medical schemes, issuing of documentation or any other administrative function required by the practice.

The practice makes use of a medical billing service company, namely Premier Billing Solutions (Pty) Ltd and I grant my consent to the processing of my medical information by Premier Billing Solutions as is required to process claims with medical schemes.

I accept that my personal information will be accessed and processed by my Medical Scheme and/or health insurer and grant the practice and Premier Billing Solutions consent to transmit that information as required to process any claims.

I accept that my personal information will only be utilized for the purpose it was collected for and that the information will only be retained for as long as is necessary and required by law, and that I have the right to view such information at any time.

GENERAL

I hereby confirm that:

- I have freely chosen this practice to consult with and render service to me;
- I am aware that my doctor's availability is limited to office hours and consulting times.
- I am under the obligation to inform the practice of changes to my personal, medical and/or financial information;
- I hereby understand that my doctor has the right to change his/her mind about a medical decision at any time;
- I have had an opportunity to review these terms and conditions and that this form accurately reflects my wishes;
- I have read and understood each of the terms and conditions contained in this agreement;
- I have a right to inspect and/or copy these terms and conditions;
- I am signing these terms and conditions voluntarily;
- I have been informed that should my medical scheme not settle the account of the practice in full, I hereby consent to authorise the practice to challenge my medical scheme at the Council for Medical Schemes on my behalf.

I agree that all the information that I have supplied is true and correct to the best of my knowledge. I have read, understand, and accept the content of these terms and conditions. And acknowledge and accept that they are legally binding upon me.

SIGNATURE:

FULL NAME:

DATE: