Maritzburg Orthopaedic Centre

Drs. Morrish, Bhagwan and Partners

Practice No: 2805928 Tel: 0333420416 Email: mthambo@sai.co.za

PATIENT INFORMATION

Surname: Title: Mr.☐ Mrs.☐ Ms.☐ Miss.☐ Prof.☐ Dr.☐ Other.☐

First Name:
(AS PER ID DOCUMENT)

Date of Birth:

ID No.: Age

Residential / P O Box Address:	Work Address:
Post Code:	Post Code:

Occupation:

Tel: (H) Tel: (W)

Cell: Email:

MAIN MEMBER'S MEDICAL AID DETAILS OR PERSON RESPONSIBLE FOR ACCOUNT(CASH/PRIVATE)

(NOT APPLICABLE IF PATIENT IS THE MAIN MEMBER)

Main Member Surname : Mr.☐ Mrs.☐ Ms.☐ Miss.☐ Prof.☐ Dr.☐ Other. ☐

Main Member Name : Main Member ID No.:

Address: (Postal or Residential)	Work Address:
Post Code:	Post Code:

Occupation: Employer:

Tel:(H) Tel: (W)

Cell: Email:

MEDICAL AID DETAILS

Medical Aid Name:

Membership Number:

Option:

GAP: Yes ☐ No ☐

Referring G.P / Doctor:

NEXT OF KIN INFORMATION

Surname:

Name:

Relationship to Patient:

Contact Number: Email:

Please turn over, read carefully and sign if you agree with these terms and conditions

PATIENT TERMS AND CONDITIONS

INFORMED CONSENT
The patient and/or person(s) responsible for payment of the account acknowledge his/her/their right to question “the doctor regarding any general queries or concerns pertinent to the specific medical procedure and/or treatment provided, including:

- treatment and diagnostic options, side effects, benefits, risks, costs, consequences, diagnosis details, prognosis if left untreated, general uncertainties, experimental treatment, monitoring and reassessment,
- the right to a second opinion,
- the name of the doctor who will have overall responsibility for treatment.
- The patient and/or person(s) responsible for payment of the account confirms that this information has been provided.
- The patient and/or person(s) responsible for payment of the account confirms that no guarantee or representation has been given by the doctor as to the treatment and/or procedure results.
- The patient and/or person(s) responsible for payment of the account acknowledge that the Service provider accepts no liability for loss, whether direct, indirect or consequential, resulting due to harm or injuries that occurred in circumstances outside their reasonable control and responsibility.
- The patient and/or person(s) responsible for payment of the account consent to the performance of any medical procedure and/or injection and/or administration of any drug deemed necessary by the doctor in the provision of treatment.

DISCLOSURE OF MEDICAL INFORMATION
The patient and/or person(s) responsible for payment of the account consent to:

- the use and disclosure of their medical information in the provision of treatment and administration of their respective accounts.
- the doctor disclosing medical information to relevant third parties including their medical aid. This information will typically include their ICD10 codes, procedural codes and diagnoses.
- The doctor accessing the hospital records, radiology reports and laboratory results.

PRIVACY OF MEDICAL INFORMATION
The patient and/or person(s) responsible for payment of the account acknowledge that:

- a copy of their information will be kept on file.
- The doctor has implemented reasonable security measures to guard against the unauthorized disclosure of patient information.
- Their authorization may be withdrawn.
- Personal information may be disclosed without patient consent as required by law.

SAFEGUARDING OF INFORMATION
The patient and/or person(s) responsible for payment of the account agree that:

- Once the doctor has handed their information to a third party, they have no further control over this information and are not liable for the safeguarding of this information.
- The patient and/or person(s) responsible for payment of the account accordingly indemnifies the doctor against any claims resulting from the wrongful use and/or disclosure of this information.

PAYMENT OF MEDICAL COSTS
The patient and/or person(s) responsible for payment of the account acknowledge that:

- The doctor is not contracted to any medical aid and fees are assessed and charged above the medical scheme rate.
- Payment of the account must be made within 30 days of the treatment.
- The benefit paid by a medical aid frequently does not match the fee charged by the doctor and a co-payment is likely payable.
- The patient and/or person(s) responsible for payment of the account is full responsibility for obtaining the required medical aid authorisation.
- If the medical aid declines payment for any reason whatsoever, the patient and/or person(s) responsible for payment of the account remains responsible for full payment in accordance with these terms and conditions.
- The doctor may submit accounts to medical aid, however, the patient and/or person(s) responsible for payment of the account take full responsibility for ensuring their medical aid and/or gap cover receive their account.
- The doctor will charge interest at 2% above prime on all accounts over 60 days.

GENERAL
The patient and/or person(s) responsible for payment of the account confirm:

- They have freely chosen to consult with this doctor.
- An obligation exists to inform the doctor of changes to their personal, medical and financial information.
- A copy of these terms and conditions will be provided on request.
- These terms and conditions are signed voluntarily.
- The patient and/or person(s) responsible for payment of the account has read the terms and conditions and agrees to be bound by same.

The patient and/or person(s) responsible for payment of the account agree as follows:

1. The patient and/or person(s) responsible for payment of the account accepts that their medical aid may not cover all of the fees charged by the doctor.
2. The patient and/or person(s) responsible for payment of the account will be jointly and severally liable, accept responsibility and guarantee payment of the full value of the account, irrespective of whether they belong to a medical aid, any medical aid claims made, paid, paid in part, rejected or exceeding any estimated quotation.
3. The patient and/or person(s) responsible for payment of the account nominate the abovementioned address under “person responsible for account payment” as their domicilium citandi et executandi.
4. Should the patient and/or person(s) responsible for payment of the account fail to make payment, the patient and/or person(s) responsible for payment of the account accept responsibility for payment of all collection expenses incurred on an attorney and client scale including collection commission, before and after the issue of summons for any sum due in terms of their account.
5. The costs associated with the medical treatment and/or procedure have been explained, and the onus is on the patient and/or person(s) responsible for payment of the account to request a quotation in writing from the doctor prior to any services rendered. The patient and/or person(s) responsible for payment of the account agree to the abovementioned conditions and all personal information recorded herein is complete, accurate and provided voluntarily.

Name:	Date:
Signature:	