DR DES ROSSOUW

2020

MBChB, MMed (Psych)

Psigiater / Psychiatrist - Tel: 012-348-0644/5

PR: 2202557

LêER NR / FILE NUMBER: .....

HOOF LID VAN MEDIES / PERSOON VERANTWOORDELIK VIR REKENING / MAIN MEMBER OF MEDICAL AID / PERSON RESPONSIBLE FOR ACCOUNT

Name & Surname / Naam & Van: .....Title/Titel:.....

ID Nr: .....

Woonadres / Home Address: ..... **Cell/Sel Nr: .....**

..... **Kode / Code: .....**

Huistaal /Language: ..... **Tel;(H) .....**

Posadres / Postal Address: ..... **Poskode / Postal Code: .....**

E-Posadres / E-Mail Address: .....

Werkgewer / Employer: ..... **Tel (W):. .....**

PASIëNT BESONDERHEDE / PATIENT DETAILS

Mnr/Mev/Me ID Nr: .....

Name & Surname/ Naam & Van: .....

Werkgewer/Employee: ..... **Work/Werk Nr: .....**

Telnr / Tel No: ..... **Cell No: .....**

Huistaal / Language: .....

MEDIESE FONDS / MEDICAL AID

Fonds / Medical Aid: ..... **Nr / No: .....**

Opsie of Plan /Option or Plan: ..... **Afhanklike/Dependant: .....**

Hooflid / Main member: ..... **GAP COVER: .....**

NAASBESTAANDE / NEXT OF KIN

Naam / Name: ..... **Verwantskap / Relationship: .....**

Adres / Address ..... **Tel: .....**

VERWYS DEUR : REFERRED BY

Naam / Name: ..... **Tel: .....**

TEKEN ALLE BLADSYE ASB/PLEASE SIGN ALL PAGES

BLAAI OM ASB /PLEASE TURN OVER

PATIENT TERMS AND CONDITIONS

THIS IS A LEGALLY BINDING AGREEMENT between

DOCTOR: DR DES ROSSOUW

HPCSA number: 0234540

And _____

ID NO: ----------

(Please fill in your name and ID number)

Please read this agreement carefully, and do NOT sign this agreement unless you fully AGREE and UNDERSTAND with these terms and conditions.

INFORMED CONSENT

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

- the different diagnostic and treatment options generally available to me.
- common and serious side effects of a 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 or the fact that the treatment is experimental.
- 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.
- whether students will be involved, and the extent of their involvement.
- that I have the right to seek a second opinion at any time.

GENERIC MEDICINE

I understand and acknowledge that:

- my Medical Scheme may insist that I substitute medicine that appear on my prescription with its generic equivalent.
- no substitution may take place in instances where the doctor has indicated (written) 'no generic substitution' on my prescription.
- it is within my doctor's sole discretion whether or not to allow for the generic substitution of my medicine.

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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.
- the processing, use and storage of my medical information as may be necessary in the circumstances.
- the disclosure of relevant medical information to my Medical Aid. This type of information will typically include my diagnosis and my ICD-10 diagnostic code.

PRIVACY OF MEDICAL INFORMATION

I understand and acknowledge that:

- This practice takes the privacy of its patient very seriously and has implemented reasonable security measures to guard against the unauthorized disclosure of my patient information.
- I may revoke my authorization in writing at any time.
- my medical information will not be disclosed to unauthorised persons.
- my patient information may be disclosed by this practice 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 charge the rates that my Medical Aid may have decided upon.
- my Medical Aid and plan of choice may or may not cover all the fees charged by this practice (*for more information regarding which benefits your chosen medical aid plan includes and/or excludes please contact your Medical Scheme*).
- I am aware that the values for services are available from my Medical Aid according to the option I have chosen.
- I am fully responsible for payment for services rendered and should I not pay timorously, understand that I will be liable for debt recovery costs on an attorney and own client scale.
- I am aware that I will be responsible for payment of account should I not cancel my appointment within 24 hours.

PRE-AUTHORIZATION

I am fully aware of the fact that if a procedure requires hospitalization:

- I am responsible to ensure that my Medical Aid covers the financial cost of the procedure BEFORE I undergo the procedure.
- my Medical Aid would generally contact my doctor to discuss the appropriateness of the procedure or to ask him for a motivation for the procedure.
- that my doctor may discuss the appropriateness of the procedure or motivation for the procedure with my Medical Aid.

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 be disclosed on the certificate and the decision who I want to show the certificate to is in my sole decision.

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GENERAL

I hereby confirm that:

- I have freely chosen this practice to consult with.
- I am aware of the fact that the availability of my doctor is generally limited to office hours and consulting times.
- I have had an opportunity to review these terms and conditions and that this form accurately reflects my wishes.
- I have been made aware of any potential conflicts of interest my doctor may have.
- I have read and understand each of the terms and conditions contained in this agreement.
- I am aware of the fact that I am entitled to request this practice to translate this document into one of the eleventh official languages, or alternatively, to have someone explain it to me in one of these languages.
- I am signing these terms and conditions voluntarily without being forced, influenced, pressured or harassed to do so.

I hereby understand that:

- my doctor has the right to change his mind about a medical decision at any time.
- I am under the obligation to inform the practice of any relevant changes to my personal, medical and/or financial information.
- I am under no obligation to sign this form.
- I have a right to inspect and/or copy these terms and conditions, and my medical file in the practice.

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

Signature ……

Date ……

FOR OFFICE USE ONLY

Please ensure that copies of the following documents are attached to this document:

- *Copy of the patient's ID document*
- *Copy of the patient's Medical Scheme Card*

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