DR DES ROSSOUW

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/Employer: ..... **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: .....**

BLAAI OM ASB /PLEASE TURN OVER

SIGN .....

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.

SIGN ……

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 timeously, 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.

SIGN …….

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.
- In line with the POPI Act, I confirm that the above details have been provided willingly and that I have given consent to the practice to use these details for the purposes needed for my treatment.
- I have read and understand the POPIA act by the practice.
- I give consent to be contacted by the practice electronically, phone, sms, whatsapp and agree to keep my electronic devices safe and password protected.
- I expect the practice to do all that is possible to protect my personal information

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- I forbid the practice to use my identifying information for any other use that is not related to my treatment process**.**

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 ……

TEKEN EN BLAAI OM ASB/PLEASE SIGN AND TURN OVER

CONFIDENTIALTITY, POPIA and DATA RETENTION

All information handled by the practice is regarded and treated as strictly confidential by the healthcare professional and the practice staff. Legislation compels the practice to provide certain information on accounts, including diagnostic information. Failure to submit the correct codes might lead to the claim being incorrectly paid or rejected by your medical scheme of funder. The Practice must also disclose ICD-10 codes on referral letters, requests for special investigations (e.g. radiology, pathology) etc.

In the event of a third-party request for confidential information from the practice, and in doubt regarding the safety of confidentiality processes, the practice may insist on following the standard operating procedures legislated in any legislation.

You hereby consent in terms of the Protection of Personal Information Act 4 of 2013 ("POPIA") as amended from time to time, that the practice may share your personal information (including diagnostic information) for practice administration services, including external practice administration providers contracted by the practice, historical, statistical, research purposes, or practice business planning with other service providers to enhance systems and services, this to include sharing with the personal information with other Healthcare Practitioners, Medical Schemes and their relevant administrators, Claim/Invoice Switch Houses in the course of providing the services to you. Your participation in this regard is highly appreciated.

Your personal information will be securely retained by the practice after your last visit to the practice, for as long as is required by legislation.

The Practice shall not transfer or authorise the transfer of Personal Information to countries outside of the Republic of South Africa without your prior written consent (which written consent you hereby provide in terms of section 72 (1) (b) of POPIA to allow such transfer outside the Republic of South Africa) for the purposes as defined in the POPIA and specifically to provide the required services to the Practice ad to you.

If Personal Information processed under this Agreement is transferred from the Republic of South Africa to third party in another country, the transferring Party shall comply with sections 72, 57 and 58 of POPIA.

This portion of this Agreement is only applicable to Practices with their Data Subject's Personal Information (PI) (your PI) located within the jurisdiction of the POPIA.

You further hereby consent that the Practice may contact you by any one of the following communication methods/platforms/systems ("communications"); namely: phone, SMS, Email, social media platforms such as WhatsApp, Telegram, Signal or similar services or any future communications. You understand that these communications will be used for professional communication only. This will include (but not be limited to) accounts, statements and information, practice information, system updates, professional updates, prescriptions, and reports where necessary and indicated. You acknowledge that none of these communications are completely secure or encrypted communications, and you will not hold the Practice responsible for any breach of confidentiality via these communications.

By signing this document, I agree I have read and agree to above

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Name and Surname **Signature**