HILLS MEDICAL CENTRE

FILE NO: _____ **DR Muller Smit (Practice Number:0446637)**

PLEASE COMPLETE IN FULL. NO APPLICATIONS WILL BE ACCEPTED IS NOT FULLY COMPLETED

PATIENT DETAILS

FIRST NAMES:	**SURNAME:**
INITIALS:	**TITLE AND GENDER:**
RESIDENTIAL ADDRESS:	**POSTAL ADDRESS:**
TELEPHONE (H):	**(W):** **(C):**
ID NUMBER:	**DEPENDANT CODE ON MEDICAL AID:**
EMAIL ADDRESS:	

NB NEEDS TO BE COMPLETED -NEXT OF KIN

NAME AND SURNAME:	**CONTACT NUMBER:**

I hereby accept that the practice may contact me to convey general information about the practice and my healthcare by means of different types of telecommunications and social media.

SIGNATURE

SHARING OF PATIENT'S INFORMATION

I hereby consent to the sharing of medical information with the relevant Medical Aid, Referral doctors, Attending Doctors, Practice Manger, Receptionist, Registered Nurse, Elixer and Practice Perfect.

If a patient wants to keep information private, the patient will be billed as private and payment will be made at reception after consultation (card or cash). If a patient does not convey their preference, we will assume that we may email to mentioned groups. Please be aware that information is stored on Practice Perfect and Elixer programmes on the server computer of the practice, as well as on external hard drive backup.

I also consent to, in the event of my account being in arears, that a statement (with medical information) will be handed over to a debt collecting agency. I am aware that if handed over to a debt collecting agency, and may result in a negative credit record.

SIGNATURE

HILLS MEDICAL CENTRE

PARTICULARS OF PERSON RESPONSIBLE FOR ACCOUNT/ PRINCIPAL MEMBER OF MEDICAL AID

PLEASE COMPLETE IN FULL

FIRST NAME:	**SURNAME:**
TELEPHONE (H):	**(W):** **(C):**
ID OR PASSPORT NUMBER:	**EMAIL ADDRESS:**
MEDICAL SCHEME:	**MEDICAL AID NUMBER:**
MEDICAL SCHEME OPTION:	**DEP CODE:**
RESIDENTIAL ADDRESS:	
POSTAL ADDRESS:	
NB Medical AID OR NOT NEEDS TO BE COMPLETED **EMPLOYERS NAME AND CONTACT DETAILS**	

Terms and Conditions:

I hereby acknowledge that I have understood and agreed to the following:

- The above-mentioned residential address is the domicilium citandi ex executandi (the address nominated by yourself, where legal notices may be sent) for all purposes.
- To abide by the terms and conditions of the practice, especially those regarding the payment of accounts.
- All accounts must be settled **within 30 (thirty) calendar days** from the date the account was created.
- The person listed as the principal member of the medical aid scheme on this form, is indeed a member with a valid membership at the time of visiting the practice.

SIGNATURE:	DATE:

NB NEEDS TO BE COMPLETED -NEXT OF KIN

NAME AND SURNAME:	**CONTACT NUMBER:**

HILLS MEDICAL CENTRE

DATE : _____

Terms and conditions:

1. I, the undersigned understand that, in my personal capacity, I remain responsible for the settlement of any costs arising from any service that myself and/or my dependent/s received and/or will receive. Payment of accounts can be done in any of the following methods: cash, debit or credit card, EFT or membership of a medical aid scheme (cheques are not accepted). If this practice is not 'contracted in' with my medical aid scheme, or if the fund is depleted, I will be responsible for the account.
2. I understand that telephonic consultations and prescription requests may have costs involved.
3. I authorize the practice to present for payment to the medical aid scheme any amount owed to the practice in respect of the patient and/or myself.
4. I understand that it remains my duty to ensure that all claims are received by the medical aid scheme timeously. The practice shall incur no liability in instances where claims are not submitted to the medical aid scheme timeously.
5. I also authorize, Dr Muller Smit (practice no.0446637) to release any information required to process my claims.
6. In the event of an account being in arears which has been referred to attorneys and/or collection agency for collection, to be liable for the payment of all costs on an attorney and own client scale, including collection commission and all tracing costs. All outstanding amounts will be recovered in the following order: attorneys, collection agency fees, collection commission, tracing fees, interest and lastly capital.
7. In accordance with legal requirements the doctor is granted permission to disclose any information about the responsible person and/or the patient, including medical information and/or diagnosis or diagnostic codes to the relevant third parties (e.g. funders, administrators, switching companies, pharmacies) for purposes of processing payment of accounts. The responsible person and/or patient have been informed that, in certain circumstances, such as disclosure of ICD10-codes, the exact consequence of disclosing such information is unknown to the doctors and that information relating to these consequences must be obtained by responsible person and/or patient from the third party to whom the information is disclosed.
8. A full consultation will be charged in the case of a patient not honouring their appointment without prior notification.
9. I agree that it is the responsibility of the member to obtain pre-authorisation for procedures. The member will carry all costs/penalties incurred as a result of failed pre-authorisations. I further understand that the member is personally responsible for the payment of the of the account and ~~if~~ where applicable for submission thereof to the medical aid.
10. The information supplied to the practice is to the best of my knowledge true and correct.

Responsible Person/Main member Signature: _____