Dr. J Theron Inc

MBChB(Stell),MMed(Int)(Stell),CertPulm(SA)
PULMONOLOGIST
Practice No: 018005 0175633

Dr. MJ Vorster Inc

MBChB(Stell), MRCP (LONDON), FCP(SA), MMed(Int)(Stell), MPhil, CertPulm(SA)
PULMONOLOGIST
Practice No: 018000 0700215

PATIENT DETAILS / PASIëNT BESONDERHEDE:

Surname: Van:		Title: Titel:		Full Names: Volle Name:	
Marital Status: Huwelikstatus:		Date of Birth: Geboortedatum:		Id nr:	
Home Language: Huistaal:		Occupation: Beroep:		Home Tel nr: Huis Tel nr:	
E-pos adres: E-mail address:				Mobile nr: Sel nr:	
Employer & Address: Werkgewer & Adres:				Work nr: Werk nr:	

PERSON RESPONSIBLE FOR ACCOUNT / PERSOON VERANTWOORDELIK VIR REKENING:

Surname: Van:		Title: Titel:		Full Names: Volle Name:	
Home Address: Woonadres:				Postal Code: Poskode:	
Postal Address: Posadres:				Postal Code: Poskode:	
Work Adress & Name of Company: Werksadres & Naam van Maatskappy:				Postal Code: Poskode:	
Home Tel nr: Huis Tel nr:		E-pos adres: E-mail address:			
Tel no & code (w) Tel nr & kode (w)		Mobile nr: Sel nr:			

MEDICAL AID / MEDIESE FONDS:

Name of Medical Aid: Naam van Mediese Fonds:		Plan: Opsie:	
Main Member: Hooflid:		Main Member ID: Hooflid ID:	
Medical Aid Number: Mediese Fonds Nommer:		Dependant Code of Patient: Afhanklike Kode van Pasiënt:	
GAP cover / GAP dekking:	Yes/Ja ☐ No/Nee ☐		

FAMILY / FRIEND (not from same household) / FAMILIE / VRIEND (nie saam woonagtig nie)

Name: Naam:		Surname: Van:	
Relationship: Verwantskap:		Contact Tel No: Kontak Tel No:	
Address: Adres:		Postal Code: Poskode:	

REFERING DOCTOR / VERWYSENDE DOKTER		Tel No: Tel Nr:	
GP / HUISDOKTER		Tel No: Tel Nr:	

Ek,..... erken die inhoud hierbo vermeld as korrek en aanvaar volle verantwoordelikheid vir die betaling van alle uitstaande rekeninge in bovermelde verband. Die praktyke onderneem om die vertroulikheid van enige vertroulike inligting waartoe die pasiënt die praktyk toegang verskaf te handhaaf en onderneem om die gemelde vertroulike inligting slegs te gebruik vir die lewering van rekenings.

Tariewe vir alle pasiënte:
Kamers: Discovery Premier B Tarief
Hospitaal: Die dokters se Privaat Tarief gebasseer op koste studies deur Healthman. Kontrak met Discovery Smart, Classic en Executive.

I, ... acknowledge the contents above as correct and accept responsibility for the payment of all outstanding accounts with regards to the above. These practices agree to maintain the confidentiality of any confidential information that the patient grants these practices to and undertakes to utilize the said confidential information for the purpose of rendering of accounts only.

Charges for all patients:
Rooms: Discovery Premier B Rate
Hospital: The doctors' Private Rate based on cost studies from Healthman. Contract with Discovery Smart, Classic and Executive.

Signature/Handtekening: Date/Datum:

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 serious 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.
- the disclosure of relevant medical information to my Medical Aid - will typically include diagnoses & ICD10 codes and procedural codes..
- the practice to have access to my hospital records, radiology & laboratorial 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 Aid may have decided upon.
- My Medical Aid 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 am fully responsible for payment and should I not pay timeously, I will be liable for debt recovery & legal costs.

MEDICAL CERTIFICATES ('SICK NOTE')

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 procedure requires hospitalization, I am personally responsible to ensure 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 to make full payment for the services rendered to me.
My Medical Scheme may request information or a formal motivation from my doctor before authorizing the procedure. I acknowledge that I am responsible to pay for the costs of such motivation or information supplied to my medical scheme.

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 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 understand 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 authorize the practice to challenge my medical scheme at the Council for Medical Schemes on my behalf.

PASIËNT TERME EN VOORWAARDES

Lees asseblief hierdie ooreenkoms noukeurig en teken as jy dit heeltemal verstaan en met hierdie terme en voorwaardes saamstem.

INGELIGTE TOESTEMMING

Ek verstaan dat ek die reg het om my dokter te vra om die mediese prosedure en behandeling aan my te verduidelik voordat ek instem tot enige mediese prosedure of behandeling, insluitend die volgende:

- die verskillende behandeling-opsies wat vir my beskikbaar is;
- die algemene en ernstige newe-effekte van 'n spesifieke behandeling;
- die voordele, risiko's, koste en gevolge wat verband hou met elke opsie;
- besonderhede van die diagnose en prognose, en die waarskynlike prognose as die toestand nie behandel word nie;
- enige onsekerhede ten opsigte van die diagnose;
- hoe en wanneer my toestand en enige newe-effekte gemonitor of her-evalueer sal word;
- Die naam van die dokter wie verantwoordelik vir die behandeling sal wees;
- dat ek die reg het om 'n tweede opinie te enige tyd in te win.

GENERIESE MEDISYNE

Ek verstaan en erken dat my mediese skema kan aandring dat ek medisyne wat op my voorskrif verskyn met 'n generiese ekwivalent vervang. Dit is my dokter se alleenreg om nie toe te laat dat generiese vervanging van my medisyne plaasvind wanneer die dokter op my voorskrif geskryf het: "Geen generiese vervanging".

MEDIESE INLIGTING

Ek magtig:

- die gebruik en bekendmaking van my mediese inligting aan enige relevante spesialis indien my primêre dokter dit nodig ag.
- dat 'n afskrif van my mediese rekord deur my dokter op lêer gehou word.
- die bekendmaking van relevante mediese inligting aan my mediese fonds – wat diagnoses & ICD10 kodes sal insluit.
- die praktyk om toegang te hê tot my hospitaal rekords, radiologie en laboratorium uitslae.

PRIVAATHEID VAN MEDIESE INLIGTING

Ek verstaan dat hierdie praktyk redelike sekuriteitsmaatreëls in plek het om die ongemagtigde bekendmaking van my pasiënt inligting te beskerm, en dat ek my magtiging te eniger tyd skriftelik kan herroep.
My pasiënt inligting kan deur hierdie praktyk openbaar gemaak word op spesiale versoek deur 'n wetstoepassingsagentskap, dagvaarding, hofbevel, of die wet.

BETALING VAN MEDIESE KOSTE

Ek erken dat:

- ek ingelig is dat hierdie praktyk nie noodwendig die tariewe hef soos deur my mediese fonds bepaal.
- my Mediese Fonds nie noodwendig al die fooie betaal wat deur hierdie praktyk gehef word nie.
- ek ten volle verantwoordelik is vir die betaling en sou ek nie betyds betaal nie, ek aanspreeklik gehou sal word vir die skuld insameling en regskoste daaraan verbonde.

MEDIESE SERTIFIKATE ('SIEK NOTA")

Ek erken hiermee dat ek verstaan dat, alhoewel ek geregtig is om te vra vir 'n mediese sertifikaat van my dokter, hy/sy onder geen verpligting is om so 'n sertifikaat uit te reik nie. My diagnose slegs bekend gemaak sal word op die sertifikaat indien ek toestemming daartoe gee en ek mag op my eie diskresie besluit aan wie ek die sertifikaat wil openbaar.

VOORAFMAGTIGING

Ek is ten volle bewus daarvan dat as 'n prosedure hospitalisasie vereis ek verantwoordelik is om te verseker dat my mediese fonds die nodige toestemming verleen en finansiële koste van die prosedure sal dek voordat ek die prosedure ondergaan. My mediese fonds kan my dokter kontak om hierdie rede, of om motivering aan te vra vir die prosedure, en ek aanvaar verantwoordelikheid vir die kostes hiervan.

ALGEMEEN

- ek bevestig dat :
- ek hierdie praktyk vrylik gekies het om mee te raadpleeg.
- ek bewus is dat my dokter oor die algemeen slegs beskikbaar is gedurende kantoorure en raadgewende tye.
- ek verpligtig is om die praktyk in te lig van veranderinge m.b.t. my persoonlike, mediese en/of finansiële inligting.
- ek verstaan hiermee dat my dokter die reg het om sy/haar opinie oor 'n mediese besluit te enige tyd kan verander.
- ek het 'n geleentheid om hierdie terme en voorwaardes te hersien en dat hierdie vorm my wense weerspieël.
- ek elkeen van die terme en voorwaardes gelees en verstaan het, soos vervat in hierdie ooreenkoms.
- ek 'n reg het om hierdie terme en voorwaardes te inspekteer en/ of 'n afskrif aan te vra.
- ek hierdie terme en voorwaardes vrywillig onderteken.
- ek ingelig is dat, indien my mediese skema nie die rekening van die praktyk ten volle vereffen nie, ek hiermee instem dat die praktyk gemagtig is om namens my my mediese skema aan te gee by die Raad vir Mediese Skemas.

By signing this document you legally bind yourself to the terms and conditions contained herein.
Deur die ondertekening van hierdie dokument verbind jy jouself wettig aan die terme en voorwaardes hierin vervat.

Signature: Date:
Handtekening ..... Datum .....