DR YOLANDI LOOTS
GENERAL SURGEON
MBChB(UFS), MMed(Surgery)(Stell), FCS(SA)
Practice Nr. 0659991

Patient registration form with terms & conditions

PATIENT INFORMATION

Title:		FULL NAME/S:		SURNAME:			
DOB:		ID/PASS NO:			GENDER:	M	F
NATIONALITY:			Weight:		Height:		

CELL:		HOME:		EMAIL:	

POSTAL ADDRESS:			
		POSTAL CODE:	
HOME ADDRESS:			
		POSTAL CODE:	

EMPLOYER		CONTACT NO	
JOB TITLE			

REFERRING DOCTOR:			FAMILY DOCTOR /GP:		
NEXT OF KIN NAME 1:		TEL:		RELATIONSHIP:	
NEXT OF KIN NAME 2:		TEL:		RELATIONSHIP:	

MAIN MEMBER INFORMATION

Title		FULL NAME/S:		SURNAME:		
DOB:		ID/PASS NO:		GENDER:	MALE	FEMALE

CELL:		HOME:		EMAIL:	

POSTAL ADDRESS:			
		POSTAL CODE:	
HOME ADDRESS:			
		POSTAL CODE:	

MEDICAL AID INFORMATION

MEDICAL AID:			SCHEME/PLAN:			
PATIENT DEPENDENT CODE:		RELATIONSHIP TO MAIN MEMBER:		GAP COVER:	Y	N
MEDICAL AID NO:			INTERNATIONAL INSURNACE:		Y	N
			MAY WE ADD DISCOVERY HEALTH ID		Y	N

PLEASE READ AND SIGN SECOND PAGE

TERMS AND 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 a specific treatment option
- 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 and re-assessed
- The name of the doctor who will have overall responsibility of treatment
- 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 appears on my prescription with its generic equivalent.
It is within my doctor's sole discretion whether 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 other medical service provider 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 diagnosis and ICD-10 codes.
- The practice to have access to my hospital records, radiology and laboratory 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 authorized disclosure of my patient information in writing at any time.
My patient information may be disclosed by the practice in response to a specific request by (but not limited to) A law enforcement agency, subpoena, court order, or as required by law

Locum: I understand that my doctor may make use of a locum tenens or associate if she is not available.

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.
- The practice does not submit to the medical aid for in-room fees, I understand that these accounts need to be settled on the day and are for my own account. Depending on your medical aid plan you may be able to claim back from your medical aid and you will be given an invoice from the practice.
- This practice charges Discovery Executive rate (300% DH base rate)
- The practice is contracted to the following medical aid schemes: Discovery Classic & Executive scheme plans & Fedhealth.
- My Medical Aid may or may not cover all the fees charges by this practice.
- It is my responsibility to familiarize myself with my Medical Aid plan.

I am fully responsible for payment and should I not pay timeously, I will be liable for debt recovery and legal costs.

Fees and conditions: I am aware of the following:

- Small in-room procedures and or other tests will incur additional costs.
- Fees related to hospital facilities and services rendered by independent healthcare professionals involved in treatment i.e. pathologist or radiologist may be incurred, and this is independent of fees charged by this practice.
- All procedures and treatments performed in the rooms require payment on the day of treatment.

Pre-authorization: I am fully aware that if a procedure is planned or requires hospitalization, I am responsible to ensure that my Medical Aid provides the required permission and covers the financial cost of the procedure **BEFORE** I undergo the procedure. My Medical Aid may contact my doctor to discuss the need, or ask for a motivation for the procedure, I accept responsibility for the cost thereof.

Medical Certificates: I understand that although I am entitled to ask for a medical certificate, my doctor is under no obligation to issue such a certificate. My diagnosis will only be disclosed on the certificate provided I have given my consent, and the decision of who I wish to show the certificate to, is at my sole discretion.

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 supply personal, medical and/or financial information that is true to this practice and that I am responsible for any false information provided.
- 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 her mind about a medical decision at any time, as may be done in my best interests as the patient.
- 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 hereby confirm that the information I supplied is true and I am responsible for any false information provided. Pleasenote: by signing this form you agree to the terms and conditions of the practice and you are responsible for the payment of the account.

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Signed at _____on / / 2021