PATIENT INFORMATION

Email completed form to: info@howickdayclinic.co.za
Address: 102 Main Street, Howick, 3290
Tele: 033 330 2725 Fax: 033 330 2739

Howick Day Clinic

Admitting Doctor : Dr ______________________ Procedure : ______________________

Date of Procedure : /20 ______________________ ICD Codes : ______________________

A: MAIN MEMBER OR PERSON RESPONSIBLE FOR ACCOUNT

Surname: ______________________ First Name/s: ______________________

Title: ______________________ Occupation: ______________________

Gender: | M | F | ID no: ______________________

Tel (H) ______________ Tel (Cell) ______________ Tel (W) ______________

Email: ______________________

Postal address: ______________________ Street address: ______________________

______________________ ______________________

Post code: ______________________ Code: ______________________

Employer: ______________________ Employer address: ______________________

____

Next of kin

Name: ______________________ Tel No: ______________________

Relation: ______________________

B: MEDICAL AID & DEPENDANT DETAILS AS ON MEDICAL AID CARD

Medical aid: ______________________ Medical aid plan: ______________________

Medical aid number: ______________________ Patient Dependant code: ______________________

Authorisation Number: ______________________ Co Payment amount if Applicable: ______________________

C: PATIENT DETAILS (if different from A)

Surname: ______________________ First name/s: ______________________

Initials: ______________________ ID no: ______________________

Date of birth: ______________________ Title: ______________________

Referring Dr: ______________________ Email: ______________________

Occupation: ______________________ Employer: ______________________

Pregnant: | Yes | No | Relation to main member: ______________________

Age: ______________________ Gender: | M | F |

Tel (H) ______________________ Tel (W) ______________ Tel (Cell) ______________

Postal address: ______________________ Street address: ______________________

______________________ ______________________

Post code: ______________________ Code: ______________________

D: INJURY ON DUTY INFORMATION

Employer: ______________________ Date of injury: ______________ Claim number: ______________

Contact person & number at employer: ______________________

PLEASE TAKE NOTE

This is a Private Practice, and our fees may exceed your benefits.
If no account has been received after 30 (thirty) days after date of service, please contact Howick Day Clinic to obtain an account.
We will submit your account to the Medical Aid on your behalf. Should this however not be paid, you will be responsible for the account.

SEE CONDITIONS OF SERVICE

CONDITIONS OF SERVICE

I, the undersigned, the patient, legal guardian guarantor of the patient referred to overleaf hereby:

1. Undertake as principle debtor, alternatively bind myself jointly and/or severally with the patient, to pay any claim of the Practice arising from medication and/or services rendered or to be rendered to the patient, notwithstanding the existence of medical aid or insurance covering the claim.

2. Acknowledge that all accounts are payable on the rendering thereof and that any accounts in arrears will bear interest at the prime overdraft rate of the practice's bankers from time to time.

3. Undertake, in the event of an account being unsettled for any reason and being referred to attorneys for collection, to be jointly and severally liable for the payment of all costs on an attorney and own client scale, all collection commission and all tracing costs. All outstanding amounts will be recovered in the following order, attorney's fees, collection commission, tracing fees; interest and lastly capital.

4. Warrant, if applicable that:
    a. I am a *bona fide* member of the stated medical aid scheme;
    b. the patient is a bona fide member/dependant;
    c. there are funds available for the patient;
    d. I have not been sequestrated and do not have any legal or contractual liabilities;
    e. the information recorded on overleaf is correct.

5. Authorise the practice or agent of the practice present for payment to the said medical aid scheme any account owed to the practice. Notwithstanding the aforesaid, it is specifically recorded that it remains my duty to ensure that all accounts are received by the medical aid scheme timeously. Neither the practice nor its agent shall incur any liability in instances where accounts are not submitted to the medical aid timeously.

6. Choose *domicilium citandi et executandi* at my physical address on overleaf;

7. Authorize the practice, or its agents, to provide information concerning the patient's treatment and/or medication to the patient's medical aid scheme, managed health care organization or insurer and their respective agents and employees dealing therewith. Should any of the aforementioned parties also be the patient's employer, then I understand that the information may also be made available to the patient's employer.

8. Acknowledge that a certificate:
    a. Signed by any doctor of the practice shall be *prima facie* proof of the patient's indebtedness to the practice;
    b. Signed by any manager of the practice's bankers (whose appointment need not be proved) shall be *prima facie* proof of the interest rate referred to in 2 above.

9. Acknowledge that I sign these conditions willingly and without duress and that no warranties or representation have been made by the practice or any of its employees regarding the content thereof.

10. Acknowledge that these conditions shall apply to all medication and services rendered or to be rendered by the practice to the patient until cancelled by me in writing under the signed acceptance by the practice.

11. Understand that the account is in respect of medication and/or services rendered by the practice only and does not include fees charged by attending surgeons/specialists or anesthetists.

PATIENT/GUARDIAN/
ON BEHALF OF THE PATIENT ....
Signature

PLEASE PRINT NAME HERE ....

GUARANTOR ....
Signature

PLEASE PRINT NAME HERE ....

DATE AND TIME ....

RECEPTIONIST ....