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

STATEMENT OF CONSENT TO DATA PROCESSING

In terms of the provisions of the Protection of Personal Information Act

I _____ (full names of patient/scheme member). ID Number _____ (the patient) hereby grant my consent to Howick Day Clinic and their appointed processor to process my personal data for the purpose of any or all of the undermentioned actions, being the legitimate reasons for processing and/or using my personal data.

I accept that my personal information will only be utilized for the purpose it was collected, that the information will only be retained for as long as is necessary and required by law, and that I have the right to view such information at any time, as well as request correction or deletion of my personal information held by the practice.

I am aware that I may withdraw my consent at any time by using the relevant data subject consent withdrawal form which is available on Howick Day Clinic's website.

Authorised actions:

- To collect and have access to my personal information
- To collect and process this information for the purpose of rendering services to me as well as processing claims with medical schemes or insurance funders.
- To handing over any outstanding accounts to debt collection third parties.
- To allow my Health Care Practitioner and his Administrative Staff access to my personal information contained in my health record, including any clinical notes, in order to process claims to medical schemes, issuing of documentation or any other administrative function required by my Health Care Practitioner.
- To use my personal information to communicate with me in person/via telephone/email/video call/fax/WhatsApp any form of social media.
- To provide the Management Group/Society to which my Health Care Provider belongs with such of my personal health information to enable them to render certain administrative services including coding queries, billing issues and audit assistance.
- To discuss any of my personal health information with any of the other members of the Clinical Team that may at any stage be involved in providing health care services to me and to forward any such information to a referring Health Care Practitioner.
- To take photographs of me where necessary and if so required the attending doctor may take these images available to my medical insurance company in order to facilitate obtaining authorization for my proposed treatment should they request such.
- To share my personal and or health information and/or clinical photographs with the clinical team involved in my treatment. This may include the use of whatsapp, email or other media as deemed necessary. I understand that although every effort is made to keep my information confidential, Howick Day Clinic cannot be held responsible for what happens to that information once it has been sent to the agreed third party.

CONDITIONS OF SERVICE

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

1. Undertake as principal 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.

STATEMENT OF CONSENT TO DATA PROCESSING

PATIENT/GUARDIAN/ ON BEHALF OF THE PATIENT	…… Signature	PLEASE PRINT NAME HERE	……
GUARANTOR	…… Signature	PLEASE PRINT NAME HERE	……
DATE AND TIME	……	RECEPTIONIST	……