COASTAL ORTHOPAEDIC GROUP

Dr DA Chivers
Orthopaedic Surgeon
MBchB; FC(SA) Orth / MMEd (UCT)
Pr: 0629790

Dr FJ Coetzee
Orthopaedic Surgeon
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Pr: 2805022

Dr V Singh
Orthopaedic Surgeon
MBchB (UCT); FCOrth (SA); MMed (Orth)(Wits)
Pr: 0774502

PATIENT INFORMATION SHEET

Patient Details	Medical Aid Details
Surname:	Gap Cover: Y ☐ N ☐
Full Names:	Main Member Name:
Title:	Main Member Surname:
DOB:	Main Member ID Number:
ID Number:	Medical Aid:
Occupation:	Plan:
Spouse / Partners Name:	Medical Aid Number:
Spouse / Partners ID No:	Patient Dependant code:
Home Postal Address:	**Next of Kin**
	Name:
Post Code:	Surname:
Work Address:	Relationship to the Patient:
	Address:
Post Code:	
Tel (H):	Post Code:
Tel (W):	Tel (H):
Cell Phone:	Tel (W):
Email:	Cell Phone:
General Practitioner	Email:
GP Name:	**Friend / Relative with a Different Address**
Referred By:	Name:
Referral Tel:	Surname:
Email:	Relationship to Patient:
Person Responsible for the Account	Street Address:
Full name:	
ID Number:	Post Code:
Street Address:	Tel (H):
	Tel (W):
Post Code:	Cell Phone:
Occupation:	Email:
Employer:	Signature of patient / parent / guardian or guarantor:
Work Tel:	…….
Home Tel:	Date:
Cell Phone:	……
Email:	

PATIENT TERMS AND CONDITIONS

'Practice' *refers* to Coastal Orthopaedics

Informed Consent

I understand that I have the right to ask my doctor to explain and disclose medical information to me before and I agree to a medical procedure or treatment, including the following

- Different treatment options available to me
- Common and serious side effects or 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 unattended
- Any uncertainties regarding the diagnosis
- How and when my condition and 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 y 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 the medicine and no substitution may take place where the doctor has written "no generic substitution" on my prescription

Disclosure of Medical Information

I hereby authorise:

- 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 diagnosis and ICD10 codes and procedure codes
- The Practice to have access to my hospital records, radiology and laboratorial results

Privacy of Medical Information

I understand that this Practice has implement reasonable security measures to guard against the unauthorised disclosure of my patient information, and that I may revoke my authorisation 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

Medical Certificates

I hereby authorise that I understand that although I am intitled to ask for a medical certificate form 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 written consent, and the decision who I want to shoe the certificate is at my sole discretion

Pre-Authorisation

I am fully aware that if a procedure requires hospitalisation, I am personally responsible to ensure that pre-authorisation is obtained from my medical aid scheme BEFORE I undergo the procedure. If my medical aid scheme declines payment for any reason whatsoever, I remain responsible to make full payment for the service rendered to me.

My Medical Scheme may request information or a formal motivation from my doctor before authorising 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 the 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 the right to inspect and/or copy these terms and conditions
- I am signing these terms and conditions voluntarily

PATIENT LIABILITY AGREEMENT

1. **The practice charges R960.00 for a consultation fee, which is payable upon consultation on the day. Cash or card payments welcome. Follow-up appointments charged at R600.00. No cheques accepted. Rates may increase without prior notice.**
2. A receipt will be issued which you need to send to your medical aid scheme for a refund of their portion.
3. All unscheduled and emergency procedures will be billed at 300% of standard medical aid rate.
4. **Please be advised that members/patients (or his/her parent or guardian) are personally responsible for any portion of their consultation or procedure not covered by the medical aid due to specific plan options or lack of funds. You remain at all times liable for payment of the account for services rendered by the practice. The Practice does not have a contract with any medical aid, you, the patient have.**
5. Any person who signs this agreement independently from the patient, parent/s or guardian shall be deemed the guarantor who accepts full responsibility for payment of the Practice invoice. The guarantor shall remain liable for the full outstanding balance/s, unless settled in full by the patient, parent/guardian, main member, medical aid or any other party.
6. **All private patients** who are not members of any medical aid will be required to pay full amount to the Practice prior to any procedure. Private patients will be provided with an estimate of the cost involved prior to any procedure being undertaken.
7. LA HEALTH PATIENTS & SELECTED OTHER MEDICAL AIDS: Please note that L A Health and selected other medical aid companies, pay all fees (operations, consultations etc) directly to the patient. ***All fees received from L A Health / your medical aid must be refunded to the Practice within 30 days of service.***
8. Missed (no-show) appointments will be billed for.
9. Treatment on medical aid cannot be changed to injury on duty at a later date.
10. **NB: If the practice obtains authorisation for a procedure, a service fee of R80.00 will be charged.** The practice charges for any additional paperwork requested by the patient or your medical aid, e.g. reports, sick notes, medical motivations and PMB application (Prescribed minimum benefit).
11. Should you not have received an account within 30 days after treatment, it is YOUR responsibility to request one. Accounts are to be settled within 30 days of service.
12. Please avoid telephone consultations and call to make an appointment. Any telephonic consultation will be billed to the patient/member.
13. **All fees due to the Practice become due and payable immediately upon presentation of a final invoice. Interest of 2% per month as well as a R50 admin fee will be charged on all outstanding accounts of more than 60 days. At 90 days, accounts will be handed over.** Collection fees will be charged to the person responsible for settlement of the account. Accounts handed over to attorneys will incur attorney and client costs for which you will be liable.
14. I, the undersigned, hereby consent and submit in terms of section 45 of the Magistrate's Court act to the jurisdiction of the appropriate magistrates court in respect of all actions or other proceedings which might be brought against me by or on behalf of the Practice arising out of my failure to pay the fee or other breach of this agreement, irrespective of the value of the claim against me.
15. The address provided hereunder are the chosen address for all purposes, including the serving of any court documents such as summonses or notices, the payment of any amounts and any communication between the parties in terms of this agreement. The party may change their chosen address by 30 day written notice to the other party.
16. Every notice, consent, invoice or other communication required or permitted in terms of this agreement, must be in writing. Notices may be delivered by hand to the address referred to hereunder, by telefax or email to the addressee's telefax number or email address, an acknowledgement of receipt from the recipient must be given to the sender or by prepaid registered post to the address referred to in the details section hereunder.
17. I hereby authorize the release of any and all relevant diagnoses to the relevant third party and give the Practice consent to claim from my medical aid and use ICD 10 codes in doing so. I have been informed that should the medical scheme not settle the account of the Practice in full, I hereby consent to authorise the Practice to challenge my medical scheme at the Council for Medical Schemes on my behalf

I have read the above, accept, acknowledge, and agree to the abovementioned terms. I confirm that the information provided by me is true and correct
By signing this document, you are legally binding yourself to the terms and conditions and liability contained herein

Name & Surname: ..... Date: .....

Address: ..... Email: .....

Signature of patient / parent / guardian or guarantor: .....