Dr Ettienne J Myburgh Inc.

Specialist Surgeon

This practice charges fees above what most medical aids pay.

Patient Information

Surname:	First Name/s:	Title:
Lang Pref: Eng ☐ Afr ☐	Date of Birth:	ID No.: Gap Cover: Yes ☐ No ☐
Tel (H):	Tel (W):	Cell:
Email:		
Home Address:		
		Postal Code:
Occupation:	Employer:	
Work Address:		
		Postal Code:

Person responsible for account / Main Member of Medical Aid

Surname:	First Name/s:	Title:
ID No.:		Gap Cover: Yes ☐ No ☐
Tel (H):	Tel (W):	Cell:
Email:		
Home Address: (If different from above)		
		Postal Code:
Occupation:	Employer:	
Work Address: (If different from above)		
		Postal Code:

Medical Aid

Fund:	Medical Aid No:
Member's names:	Option/Plan:
Dependant Code:	Gap Cover: Yes ☐ No ☐

Referring Doctor and Family Physician

Name:	Tel No:	Fax No:
Address		
Postal Code:	E-mail:	

Family Physician (if not Referring Doctor)

Name:	Tel No:	Fax No:
Address		
Postal Code:	E-mail:	
Other doctors to receive copies of reports:		

Next of Kin / Friends (not at the same address)

Surname:	First Names:	
Tel (H):	Tel (W):	Cell:
Relationship:	E-mail:	
Home Address:		
		Postal Code:

I, the undersigned, agree as follows:

1. I am personally liable for medical services rendered by the doctor to me and/or to any person of whom I am the parent or the legal guardian;
2. To pay promptly the account of the doctor in accordance with the tariff of charges prevailing in the doctor's Practice, or as agreed with me, and in the manner in which the parties have agreed;
3. To settle the doctor's account on time and in full, as agreed, irrespective of contracts / agreements / arrangements I may have with any medical scheme or any third party;
4. Should the doctor institute legal action against me for recovery of any outstanding debts, to pay all legal costs, including attorney and own client costs, collection fees and tracing fees;
5. Should the doctor hand an outstanding account over to a debt collection company, that debt collection company is the sole point of contact and I will only correspond with that company in respect of the outstanding account.
6. I acknowledge that, in accordance with the provisions of Section 53(1) of the Health Professions Act of 1974 and Section 6(c) of the National Health Act 61 of 2003, the costs associated with all medical services rendered by the doctor, treatment and/or procedures have been discussed and were fully explained to me, to the extent required in law and professional ethics.

IMPORTANT! Read and Sign. **This practice charges fees above what most medical aids will pay.**

You are responsible for the account. We will send a copy of your account to your medical aid on your behalf, but this does not imply a transfer of responsibility for payment. Any negotiations with medical aids over payments are your responsibility. Your consultation fees are payable after completion of your visit. You hereby give consent for the practice to have access to your hospital records, radiology & laboratorial results.

I hereby choose my above address as my domicilium citandi et executandi for all purposes under this agreement. I HAVE READ, UNDERSTAND AND AGREE TO THE CONDITIONS MENTIONED ABOVE. I CONFIRM THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT.

Signature: ..... Dare: .....

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.

By signing this document you legally bind yourself to the terms and conditions contained herein.

Signature ..... Date .....