Leanne Samaai
PHYSIOTHERAPY

Practice no: 0720000559164

PLEASE FILL IN THIS FORM CAREFULLY

Failure to supply correct and complete information renders Medical Aid patients liable for full payment of their account. Private patients to settle accounts on completion of treatment.

PATIENT DETAILS						
Surname:					First names:	
DR	PROF	MR	MRS	MISS	ID Number:	
Date of Birth:						
Occupation:					Employer's Name:	
Tel (W):		Tel (H):			Cell:	
Residential Address:						Code:
Postal Address:						Code:
E-mail Address:						
PERSON RESPONSIBLE FOR ACCOUNT/PRINCIPAL MEMBER (if different from the above)						
Surname:					First names:	
DR	PROF	MR	MRS	MISS	ID Number:	
Date of Birth:						
Tel (W):		Tel (H):			Cell:	
Residential Address:						Code:
Postal Address:						Code:
E-mail Address:						
Referred by:	GP:		SPECIALIST:		SELF:	
WEBPAGE:	HOSPITAL:		OTHER:		INTERNET:	
MEDICAL AID DETAILS:						
Medical Aid Name:					Number:	
Type of Plan:					Initials of Main Member:	
Hospital Plan Only:	Yes		No		Dependant Code:	
NEAREST FAMILY / NEXT OF KIN / FRIEND (Not at above address)						
Name:		Relationship:			Tel:	
					Cell:	
METHOD OF PAYMENT:	EFT	CASH	CHEQUE	CREDIT CARD	DEBIT CARD	

Please turn over

Room G18, Constantiaberg Mediclinic, Burnham Road, Plumstead, 7800

Tel/Fax: 021 7616393
After Hours: 072 2800873

Accounts: 021 7612629
email: admin@lsphysio.co.za

Dear Valued Patient

This document explains the general conditions under which this practice sees patients. It does not constitute an informed consent to any specific treatment, nor does it constitute a quotation or price for any service provided by the practice. Signing the form (below) will constitute Informed consent and price information may be requested each time you are treated by this practice. Cost will depend on the care you need/seek, and factors such as your medical scheme cover.

Medical Aids and Co-Payments

This serves as a binding contract between you the patient and the above practitioner. You may only sign on behalf of yourself or your dependants who are below 18 years of age. If you belong to a medical aid plan, each member on your plan, and who is over 18 years of age, will be required to sign a separate binding contract with this practice.

In today's medical aid market place patients are now purchasing lower cost medical aid plans, which you may, or may not realise, that by enrolling in these medical plans, you are accepting restrictive limits on your treatment with fewer benefits, medicine restrictions, limited hospital and surgery cover, government hospitals as the provider of pre-determined treatment and surgical procedures, and which doctors you may or may not see.

Your treatment, the financial costs, and the quality of your professional care can be severely affected by the type of medical plan you belong to and the general statement such as " 100% cover" by your medical aid may or may not correspond with all the aspects of treatment you may require.

These limitations often prove problematic for your therapist, as the right to obtain the necessary professional medical care that meets an acceptable standard is being influenced by your choice of medical aid cover.

Due to a possible difference in the fee for service rendered by this practice and the maximum benefit level of your medical aid plan, you may be required to make a co-payment to the practice so as to equalise such difference. In this case the practice or the medical aid will levy the co-payment difference.

You (or the parent / guardian) remain at all times liable for payment of the account for the services rendered by this practice, even if you are insured with a medical aid or third party. This agreement does not preclude the practice from taking all reasonable and practical steps so as to recover any outstanding amounts. The practice reserves the right to charge interest on your outstanding accounts due from the date of the service and up to the maximum interest allowed by section 2 of the Prescribed Rate of Interest Act. You may be held personally liable for all costs associated with the recovery of any outstanding amounts due to this practice, as well as legal costs on an attorney and own clients' basis.

It remains your responsibility to inform and update all personal and medical aid detail information with the practice and that you undertake to keep the practice regularly informed with regards to any changes on your contact details, medical aid membership, benefits, and list of dependants. Please note that the use of somebody else's medical aid card with or without such a persons' consent or knowledge whilst she/ he is not a member or dependant of such medical aid amounts to fraud. This practice will report such instances to the medical aid concerned so as to prevent the practice from being held liable as a party to such fraud.

Confidentiality

All information handled by this practice will be regarded and treated as strictly confidential by the Therapist and the practice staff. Should you belong to a medical aid and the medical aid forwards such an account to the principal member of the medical aid, confidentiality may not be absolutely preserved, as this practice is required by law to provide certain information to the medical aid on accounts submitted and failure to provide the correct codes might also lead to claims incorrectly being paid.

Regulation 5(f) of the Medical Schemes Act (published in Government Gazette No 20556 on 20 October 1999) states that an account to a medical aid must contain the relevant diagnosis. This must be submitted in the ICD-IO diagnostic coding format. It has also become necessary to disclose these codes on referral letters and requests for radiology and pathology tests.

Should a medical aid or any of its administrators approach this practice for confidential patient information and the Therapist is uncertain of the necessary confidentiality processes in place, the Therapist will insist to follow the standard operating procedures as legislated in the Access to Information Act and other legislation or rules.

Additionally, by signing this consent, you acknowledge that depending on your diagnosis, the Therapist may choose to treat you (or the patient) in an open area. This will however not be implemented in a situation where the condition is of a sensitive nature or in a situation in which you would need to undress and /or expose any sensitive areas of your body.

Signature

I hereby acknowledge that I have read the above information prior to having signed and that all information submitted by me in connection with my medical aid plan is true and correct. I understand that I am under a continuing obligation to advise the above practitioner / practice of any changes which may occur after submission of this contract and acknowledge, by signing this contract, that I am legally bound by the provisions of the contract. This contract is subject to the provisions of the National Credit Act and the HPCSA ethical rules.

I understand that this contract constitutes part of terms and conditions under which professional services will be rendered, in compliance with the provisions of the Consumer Protection Act.

Date: _______/_______/___________

Patient/Main member/Parent/Guardian signature ____________________________

Patient/Main member/Parent/Guardian ID number ____________________________

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