PATIENT REGISTRATION PROF EW HENN - OBSGYNE

PATIENT DETAILS		
Surname:	First Name:	
Title:	Date of birth:	
Occupation:	ID:	
Home language:	Marital Status:	
Religion:	Email:	
Tel(H):	Tel(W):	Cell:
Employer:	Email:	
PERSON RESPONSIBLE FOR ACCOUNT (Please see practice terms and conditions)		
Surname:	First Name	
Title:	Date of birth:	ID:
Home address:		
Postal address:		
Tel(H):	Tel(W):	Cell:
Email:		
Are you currently under debt review and/or Administration Order issued by a competent Court for the management of your debts	Yes	No
MEDICAL AID DETAILS	Dependant Code:	
Medical Aid:	Plan/Option:	
Number:	Main member:	
Authorisation Tel no:	Main member ID:	
NEXT OF KIN (Partner/Parent/Sibling/Friend)		
Name and Surname:		
Relationship:		
Tel(H):	Tel(W)	Cell:
Address:		
REFERRING PRACTITIONER		
Name:	Speciality:	
Address:		
Email:		
Tel:	Cell:	

I, the undersigned, hereby testify all the above information to be accurate to the best of my knowledge and I accept all terms and conditions as specified in the provided practice documentation.

_____ _____ _____

Printed Name Signature Date

PATIENT DECLARATION & PRACTICE TERMS AND CONDITIONS

I, the undersigned, hereby acknowledge and accept the following practice regulations:

As the self-declared person responsible for this account (irrespective of whether I am the main member of a dependant on a medical aid), I accept that I am solely responsible to settle this account irrespective of my agreement with my personal medical aid/insurance.

I acknowledge that my medical aid membership is a personal agreement between the relevant scheme and myself and that if there is any delay or dispute regarding payment, I will settle the account personally within 30 days of services rendered.

This practice reserves the right to claim directly from you, in which case you will be provided with a detailed invoice. This is payable to the practice upfront or within 3 days from date of service.

If my account becomes overdue, I am aware that 5% interest will be charge per month and that legal steps may be taken with any additional costs incurred to be added to my account.

I will notify the practice immediately, in writing, should any of my personal or medical aid information change.

I have been informed that this practice charge private healthcare rates which is more than reference price listings utilised by the medical aid/insurance schemes.

I realize that I will receive additional bills for any blood tests, pap smears, x-rays or procedures form the relevant laboratory or any other additional service provider.

I have been informed that Prof Henn reserves the right to bill specialist rates for all email and telephonic consultations as well as motivation letters, repeat scripts and medical reports according to the practice's billing policies and that he will not correspond on medical matters via sms/Whatsapp or similar platforms.

Although Prof Henn will be mostly available for after-hours services or advice, I am aware that this practice can make use of locum doctors (including general practitioners) as per the discretion of Prof Henn. This includes procedures and consultations over weekends as well as after-hour emergencies, incl. deliveries.

Appointments will be fully charge for, unless cancelled at least 24 hours in advance.

I hereby give consent to the discreet disclosure of my personal and medical information to my medical aid/insurer as well as practice and hospital staff, predominantly through the use of ICD-10 codes, and I give consent to physical record keeping of consultations.

In case of a complaint or dispute regarding care provided by either Prof Henn, his practice staff or locums used – I undertake to embark on a course of formal pre-mediation counselling and mediation, before any formal litigation is pursued.

Signed at _____ on this _____(day) of 20___

Printed Name: _____ Signature: _____