BAY UROLOGY
DR GÉRARD GROBLER UROLOGY INC.

DETAILS OF MAIN MEMBER OF MEDICAL AID / PERSON RESPONSIBLE FOR THE ACCOUNT (please obtain a copy of ID):

Full names and Surname:		
ID / Passport number:		
Cell phone number:		
E-mail address:		
Address (Physical):		Code:
Address (Postal):		Code:
Employer:		
Occupation:		
Physical address of employer:		
Contact number at employer:		Employee Code:

MEDICAL AID DETAILS (if applicable)
(Please obtain copy of the card front and back)

Medical aid:	
Medical aid number:	
Medical aid plan / option:	

DETAILS OF REFERRING DOCTOR

GP / doctor (name & surname):	
Contact number:	

FRIEND / RELATIVE AT A DIFFERENT ADDRESS

Name and Surname:	
Relationship:	
Cell phone:	

GAP Cover	**Yes / No**
Account number assigned on the system:	

Notes:

CODE

ICD 10

PATIENT DETAILS:

Full names and Surname:	
Dependent code on medical aid card:	
ID / Passport number:	
Male or female:	

GENERAL CONDITIONS:

I, the undersigned, acknowledge that I am personally responsible for payment of all fees and/or tariffs in the event of my medical aid opting, for whatsoever reason not to pay the account. In the event of divorce, the parent accompanying the minor is responsible for settlement of the account. In the event of any legal action being instituted against me for recovery of any amount whatsoever, I shall be liable for all legal costs (on an attorney and client scale), including a 20% admin fee on any instalment paid. Once my account has been handed over for collection, no further correspondence may be entered into with the practice, but only with the debt collection company or attorney chosen by the practice. I specifically acknowledge that the National Credit Act, 34 of 2005, is not applicable to this claim or any dispute that may arise from this agreement. I hereby choose the address stated above as my chosen *domicilium citandi et executandi* for all purposes under this agreement.

By signing this document, I acknowledge that I have read, that I understand, and agreed to the conditions and terms stated above or below. I confirm that to the best of my knowledge, information provided by me is both true and correct.

Rhythm Financial Services and it`s elected agent / affiliate is the account, management and debt collecting agent to the practice, and herewith agrees to maintain the confidentiality of any confidential information supplied by the patient and undertakes to utilise this information strictly for the above-mentioned purpose, which may include follow-up and feedback contact.
Tel: 051 407 0803

rhythm FINANCIAL MENTORS

Date:	
Signed:	

PATIENT TERMS AND CONDITIONS

Kindly attend to read this agreement carefully and ensure to undersign the agreement if have satisfied yourself with 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;
- 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.

GENERIC MEDICINE

I understand and acknowledge that my medical fund may insist that I substitute medicine that appears on my prescription with its generic equivalent. It is within my doctor's sole discretion whether to allow for the generic substitution of my medication 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;
- the practice to gain 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 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;
- I am fully responsible for payment and should I not pay timeously, I will be liable for debt recovery & legal costs on an attorney and client scale;
- I herewith acknowledge that my personal information may be released to third parties, which would include debt collectors and / or any agent that may be associated with legal action, which may result from outstanding / non-payment due to the practice.

MEDICAL CERTIFICATES ("SICK NOTE')

I acknowledge that I am entitled to ask for a medical certificate from my doctor, however that he/she is under no obligation to issue such a certificate. My diagnosis will only be disclosed on the certificate provided, subject that I have given my consent, and that the decision who I want to show the certificate to, is at my sole discretion.

PRE-AUTHORISATION

I am fully awarethat if a procedure requires hospitalization, I am responsible to ensure that my medical aid provides the required permission and covers the financial cost of the procedure BEFORE I undergo the procedure. My medical aid may contact my doctor to discuss the need, or toaskfor a motivation for theprocedure and I acceptresponsibility for the costs thereof.

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 request a copy these terms and conditions;
- I am signing these terms and conditions voluntarily;
- I have been informed that should my medical fund not settle the account of the practice in full, I hereby consent to authorize the practice to challenge my medical fund at the Council for Medical Schemes on my behalf.

PASIËNTTERME EN VOORWAARDES

Geliewe die ooreenkoms noukeurig deur te gaan, waarna u moet verseker om die ooreenkoms te onderteken, nadat u, uself vergewis het van terme en voorwaardes.

INGELIGTE TOESTEMMING

Ek verstaan dat ek die reg het om my dokter te versoek om aan my alle mediese inligting te ontbloot en verduidelik wat dit behels, voorts ek instem tot enige mediese prosedure of behandeling, insluitend die volgende:

- verskillende behandeling-opsies wat vir my beskikbaar is;
- algemene en ernstige newe-effekte van 'n spesifieke behandeling-opsies;
- voordele, risiko's, kostes en gevolge wat verband hou met elke opsie;
- besonderhede van die diagnose en prognose, sowel as die waarskynlike prognose as die toestand nie behandel word nie;
- enige onsekerhede ten opsigte van die diagnose;
- hoe en wanneer my toestand en enige newe-effekte gemonitor of herevalueer sal word;
- die naam van die dokter wie verantwoordelik vir die behandeling sal wees:
- dat ek die reg het om 'n tweede opinie ter enige tyd in te win.

GENERIESE MEDISYNE

Ek verstaan en erken dat my mediese fonds kan aandring dat ek medisyne wat aan my voorgeskryf is met 'n generiese ekwivalent moet vervang. Dit is binne my dokter se uitsluitlike diskresie om nie toe te laat dat generiese vervanging van my medikasie plaasvind nie en mag geen generiese vervanging plaas vind in die geval waar die dokter op my voorskrif geskryf het: "*geen generiese vervanging*" nie.

MEDIESE INLIGTING

Ek magtig hiermee:

- die gebruik en bekendmaking van my mediese inligting aan enige relevante spesialis indien my primêre dokter dit nodig ag;
- dat 'n afskrif van my mediese rekord deur my dokter op lêer gehou word;
- die bekendmaking van relevante mediese inligting aan my mediese fonds - wat in die algemeen diagnoses & ICD10 kodes salinsluit;
- die praktyk om toegang te hê tot my hospitaalrekords, radiologie en laboratorium uitslae.

PRIVAATHEID VAN MEDIESE INLIGTING

Ek verstaan dat hierdie praktyk redelike sekuriteitsmaatreëls in plek het om die ongemagtigde bekendmaking van my pasiënt inligting te beskerm en dat ek my toestemming ter enige tyd skriftelik kan herroep.

My pasiënt inligting kan deur hierdie praktyk openbaar word op spesiale versoek deur 'n wetstoepassings-agentskap, *subpoena*, hofbevel, of soos vereis deur Wetgewing.

BETALING VAN MEDIESE KOSTE

Ek erken dat:

- ek ingelig is dat hierdie praktyk nie noodwendig die tariewe hef soos deur my mediese fonds bepaal word nie;
- my mediese fonds nie noodwendig al die tariewe sal dek wat deur hierdie praktyk gehef wordnie;
- ek ten volle verantwoordelik is vir die betaling en sou ek nie tydig betaal nie, ek aanspreeklik gehou sal word vir die invordering en regskostes, op 'n prokureur en kliënt skaal, daaraan verbonde;
- ek vergewis myself van die feit dat my persoonlike inligting verskaf mag word aan derde partye, wat skuldinvorderaars insluit en/of enige agent wat geassosieer mag word met regsaksie, wat kan voortspruit uit enige uitstaande betaling en/of wan-betaling, soos verskuldig mag wees aan die praktyk.

MEDIESE SERTIFIKATE ("SIEKNOTA")

Ek erken, alhoewel ek geregtig is om te vra vir 'n mediese sertifikaat van my dokter, maar dat hy/sy onder geen verpligting is om so 'n sertifikaat uit te reik nie. My diagnose sal slegs bekend gemaak word op die sertifikaat indien ek toestemming daartoe gee en ek mag op my eie diskresie besluit aan wie ek die sertifikaat wil openbaar.

VOORAFMAGTIGING

Ek is ten volle bewus daarvan dat as 'n prosedure hospitalisasie vereis, dat ek verantwoordelik is om te verseker dat my mediese fonds die nodige toestemming verleen en finansiële koste van die prosedure sal dek VOORDAT ek die prosedure ondergaan. My mediese fonds kan my dokter kontak om hierdie rede, of om motivering aan te vra vir die prosedure en ek aanvaar verantwoordelikheid vir die kostes hiervan.

ALGEMEEN

ek bevestig dat:

- ek hierdie praktyk uit eie beweging verkies het om te raadpleeg;
- ek vergewis is dat my dokter oor die algemeen slegs beskikbaar is gedurende kantoor-ure en raadgewende tye;
- ek die verantwoordelikheid dra om die praktyk in te lig van veranderinge van my persoonlike, mediese en/of finansiële inligting;
- ek verstaan dat my dokter die reg het om sy/haar opinie oor 'n mediese besluit te enige tyd kan verander;
- ek het die geleentheid ontvang om hierdie terme en voorwaardes te hersien en dat hierdie vormmywenseweerspieël;
- ek elkeen van die terme en voorwaardes gelees t en verstaan het, soos vervat in hierdie ooreenkoms;
- ek 'n reg het om hierdie terme en voorwaardes te inspekteer en/of 'n afskrif aan te vra;
- ek hierdie terme en voorwaardes onder vrye wil onderteken;
- ek ingelig is dat, indien my mediese fonds nie die rekening van die praktyk ten volle vereffen nie, ek hiermee instem dat die praktyk gemagtig is om namens my die mediese fonds aan te gee by die Raad van Mediese Skemas.

By signing this document, you legally bind yourself to the terms and conditions contained herein.
Deur ondertekening van hierdie dokument verbind jy jouself wettig aan die terme en voorwaardes hierin vervat.

Signature / Handtekening: _____

Date / Datum: _____