SAFE HANDS
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**New patient registration** ☐ **vs.** **Change of details** ☐

**Patient details:** **Date:**

| | | |
|---|---|---|
| Surname: | First Name: | |
| Title: | Date of Birth: | Nationality: |
| Home Language: | ID/Passport No.: | |
| Marital Status: | Religion: | |
| Correspondence address: | | |
| Place of work: | Occupation: | |
| Preferred Contact number: | Email: | |
| Tel (H): | Tel (W): | Mobile: |

**Person responsible for account, if not patient** (Please see practice terms and conditions)

| | | |
|---|---|---|
| Surname: | First Name: | |
| Title: | Date of Birth: | ID: |
| Postal Address: | | |
| | | |
| Tel (H): | Tel (W): | Mobile: |
| Email: | | |

**Are you currently under debt review and/or under Administration Order issued by a competent court for the management of your debt?** **Yes** ☐ **No** ☐

**Medical Aid Details**

| | | | | | |
|---|---|---|---|---|---|
| Medical Aid: | Main Member: | | | | |
| Number: | Main Member ID: | | | | |
| Plan/Option | Do you have Gap Cover? | **Yes** | ☐ | **No** | ☐ |

**Next of kin / In case of emergency contact** (Partner/Parent/Sibling/Friend)

| | | |
|---|---|---|
| Name and Surname: | | |
| Relationship to patient: | | |
| Tel (H): | Tel (W): | Mobile: |
| Address: | | |
| | | |

**Referring practitioner:**

| | |
|---|---|
| Name: | |
| Speciality: | |
| Practice name/address: | |
| Tel: | Email: |

**I, the undersigned, hereby testify that all the above information is accurate to the best of my knowledge and I accept all terms and conditions as specified in the provided practice terms and conditions. I have been granted opportunity to discuss any questions and concerns and information has been provided/ explained to me in a language I am comfortable with.**

Name: _____ Signature: _____ Date: _____

## PLEASE READ THIS AGREEMENT CAREFULLY, AND SIGN IF YOU FULLY AGREE AND 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, including 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;
- That I have the right to seek a second opinion at any time.

### 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 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 (physical/electronic/audio);
- The disclosure of relevant medical information to my Medical Aid - will typically include diagnoses and ICD10 codes;
- The practice to have access to my hospital records, radiology and laboratorial results.

**Through this document, I have been informed that Dr D Krick is not covered by the medical malpractice insurance by the Medical Protection Society and in case of a complaint or dispute arising regarding the care provided by either Dr D Krick, her practice staff or locum associates - I undertake to embark on a course of formal mediation before any litigation is pursued.**

### 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.
- This practice charges above Medical Aid rates. Private rates (180-300%) which is more that the Reference price List (RPL) as prescribed by the Department of Health.
- My Medical Aid may or may not cover all the fees charged by this practice.
- As the self-declared person responsible for this account (irrespective whether I am the main member or as 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.
- If my account becomes overdue, I am aware that 2% interest will be charged per month and that legal steps may be taken with any additional costs incurred to be added to my account.
- I am aware that I will receive additional bills for any surgical assistants, blood tests, Pap smears, x-rays, ultrasound or procedures from the relevant laboratory or healthcare provider other than Dr D Kick.
- I have been informed that Dr D Krick reserves the right to bill specialist rates for all email/telephonic consultations, missed appointments, motivation letters and repeat scripts according to the practice's billing policy and that **she will not correspond at all via SMS/WhatsApp.**
- Appointments will be fully charged for unless cancelled **MORE THAN 24 HOURS** in advance.

### Medical Certificates ('SICK NOTES')

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 obligations to issue such a certificate. My diagnosis will only be disclosed on the certificate provided I have given my 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 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 ask for a motivation, for the procedure and I accept responsibility for the costs thereof.

### GENERAL: I hereby confirm that:

- I am aware of the fact that the availability of my doctor is generally limited to office hours and consulting times; this practice will make use of locum doctors (including male doctors) as per the discretion of Dr D Krick, this includes deliveries as well as after-hours emergencies.
- I am under the obligation to inform the practice of changes to my personal, medical and/or financial information.
- I have read, had the opportunity to review, understand and agree to each of the terms and conditions in this document.
- I have freely chosen this practice to consult with and 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. Signed at Netcare Christiaan Barnard Memorial Hospital (Cape Town)**

**Client -** Printed Name: _____ Signature: _____ Date: _____