DR SIRK B LOOTS - CBMH PATIENT INFORMATION

Dr/ Prof/ Mr / Mast/ Miss/ Mrs/ Ms NAME & SURNAME:	Married / Single / Divorced	FILE NO.
ID. No.:	Male / Female	
Date of Birth:	Home Language	
Tel. (H)	Tel.(W)	
Cell.	Email:	
Physical Str. Address:	Fax:	
	Post Code:	
Postal Address:		
	Post Code:	
Occupation:		
Allergies:		
Medical Conditions:		

Previous Surgery:	
Current Medication:	
Full Names of Person Responsible for Account:	Dr/Prof/Mr/Miss/Mrs/Ms
NAMES:	ID No.
Relationship to Patient:	Occupation:
Employer Name&Address:	Employer Ph:
	Post Code:

Physical (home)Address:		Cell:
		Post Code:
P O Box Address:		
		Post Code:
Medical Aid Name:		
Medical Aid No.	**M/Aid Plan:**	
Name of referring Doctor:		
Tel. No.	Fax. No.	
Referring Dr's Email Address:		
EMERGENCY CONTACT : FAMILY MEMBER / CLOSE FRIEND		
Contact Name:	Relationship:	
Tel. (H)	Tel.(W)	Cell.

PLEASE NOTE: Our rates are based on the **Ethical Tariffs**, as recommended by the Health Professional Council of South Africa.
Payment for consultations (not covered by medical aids) is to be made on the day of the consult.

Please be advised additional accounts may be received, from independent service providers, for items provided to patients in our rooms or subsequent to a hospital procedure (Wrist braces, Foam walkers, Moonboots, etc.).

Medical Aid Patients

Medical Aids decide independently what they are prepared to contribute to procedures and treatments.

Please consult with your Medical Aid prior to admission/consultation, to obtain pre-authorisation, if necessary. Any short payments by your Medical Aid will be for your own account.

We happily assist our patients in submitting their accounts to Medical Aids, but please keep in mind that ultimately the responsibility of settling an account, lies solely with the patient.

Private Patients

Please contact our offices prior to admission/consultation, to establish the estimated cost of your procedure.

Depending on your procedure, your account may be a fixed- or an estimate only fee. As theatre/hospitalization time, medication and surgical materials vary, it is not always possible to provide a fixed cost. If the Actual Account varies from the Estimate, the patient will receive a back payment or will be required to pay the difference between the estimate and the actual amount.

Payment methods:

- Major Debit/Credit cards
- Electronic Funds Transfer (EFT)
- Cash

Please Note: If using EFT, proof of payment is required prior to admission/consultation, unless in the case of an emergency.

This practice is not able to offer credit.

Do not hesitate to contact our offices (021–424 0012 / 021-671 4575), to discuss any queries or payment arrangements.

Scheduled appointments must be cancelled with 24 hours' notice. Patients may be charged for missed appointments.

I HAVE READ ALL THE INFORMATION ON THIS SHEET. I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR THE ACCOUNT OF THE DOCTOR.

SIGNATURE: _____

PRINT NAME: _____

DATE: _____

I CONSENT / DO NOT CONSENT - TO THE DISCLOSURE OF ICD10: CODING ON MY BEHALF
(ICDQO code - descriptive code of the injury that you sustained and how it occurred)

DETAILS OF ACCIDENT: _____

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