DR JASON CRANE
ORTHOPAEDIC SURGEON

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For Office Use / Vir Kantoor Gebruik

Account No/Rekening Nr _____ Date/Datum: _____

PATIENT DETAILS / BESONDERHEDE VAN PASIËNT

Surname / Van _____ Initials/Voorletters _____ Title/Titel _____

First Name / Voornaam _____ Gender/Geslag Male/Man Fem/Vrou

ID No./Nr. _____ Date of Birth/Geboortedatum _____

Physical Address/Fisiese Adres _____

_____ Code/Kode _____ Tel: (____) _____

Postal Address/Posadres _____

_____ Code/Kode _____ Cell/Sel: _____

Occupation / Beroep _____

Employer/Werkgewer _____ Tel: (____) _____

Business Address/Werksadres _____ Code/Kode _____

Next of Kin/Naasbestaande _____ Relationship/Verwantskap _____ Tel: (____) _____

Gap Cover/Gapingsdekking Yes/Ja☐ No/Nee☐ Policy No/Polis nr:_____

MEDICAL AID DETAILS / MEDIESE FONDS BESONDERHEDE *(please complete all the fields/voltooi asb alle velde)*

Medical Aid Name/Naam van Mediese Fonds _____

Medical Aid Number/Mediese Fondsnommer _____

Medical Aid Plan/Mediese Fonds Plan _____ Dependant No/Afhanklike Nr _____

Gap Cover/Gapingsdekking Yes/Ja☐ No/Nee☐ Policy No/Polis nr:_____

MEMBER/PERSON RESPONSIBLE FOR PAYMENT / LID/PERSOON VERANTWOORDELIK VIR BETALING

Name/Naam _____ Tel: (____) _____ Cell/Sel: _____

ID No./Nr. _____ Date of Birth/Geboortedatum _____

Postal Address/Posadres _____

_____ Code/Kode _____

Occupation / Beroep _____

Employer/Werkgewer _____ Tel: (____) _____

Business Address/Werksadres _____ Code/Kode _____

E-mail address/E-pos adres: _____

REFERRING DOCTOR / VERWYSENDE GENEESHEER

Surname/Van _____ First Name/Voornaam _____

Practice Location/Praktyk Ligging _____

General Practitioner / Algemene Praktisyn (If different than referring Doctor / Indien verskil van verwysende Geneesheer)

Surname/Van _____ First Name/Voornaam _____

PLEASE NOTE / NEEM ASSEBLIEF KENNIS

This practice charges in excess of NHRPL tariffs (Medical Aid Rates). The following is applicable to ALL patients:
A fixed fee of R600 is payable for 1st consultations and R450 for follow-up visits. This excludes procedures/consumables.
Unscheduled Emergency Consultation – ± R622.80 (This amount may vary according to each medical aid rate applicable).
Surgery includes 6weeks of follow-up, thereafter R450 will be charged for consultations.
Hierdie praktyk se fooie oorskry die NHRPL tariewe (Mediese Fonds). Die volgende is van toepassing vir ALLE pasiënte:
'n Vaste fooi van R600 is betaalbaar met 1ste konsultasies en R450 met opvolg besoeke. Prosedures/voorraad word uitgesluit by bogenoemde.
Ongeskeduleerde nood-konsultasie – ± R622.80 (Hierdie bedrag mag varieer volgens verskillende mediese fonds tarief toepassings).
Prosedures sluit in 6weke van opvolg, daarna n fooi van R450 betaalbaar vir konsultasies.

SEE REVERSE FOR CONDITIONS OF SERVICE / SIEN KEERSY VIR VOORWAARDES VIR DIENSLEWERING

CONDITIONS OF SERVICE

I, the undersigned, the patient, legal guardian, guarantor of the patient referred to overleaf hereby:

1. undertake as principal debtor, alternatively bind myself jointly and/or severally with the patient, to pay any claim of the Practice arising from medication and/or services rendered or to be rendered to the patient, notwithstanding the existence of medical aid or insurance covering the claim;
2. acknowledge that all accounts are payable on the rendering thereof, and that any account in arrears will bear interest at the prime overdraft rate of the Practice's bankers from time to time;
3. undertake, in the event of an account being unsettled for any reason and being referred to attorneys for collection, to be jointly and severally liable for the payment of all costs on an attorney and own client scale, all collection commission and all tracing costs. All outstanding amounts will be recovered in the following order: attorney's fees, collection commission, tracing fees; interest and lastly capital;
4. warrant, if applicable, that:
   - 4.1. I am a *bona fide* member of the stated medical aid scheme;
   - 4.2. the patient is a *bona fide* member/dependant;
   - 4.3. there are preference funds available for such patient;
   - 4.4. I have not been sequestrated and do not suffer from any legal or contractual disability;
   - 4.5. the information recorded overleaf is correct;
5. authorise the Practice or agent of the Practice to present for payment to the said medical aid scheme any account owed to the Practice. Notwithstanding the aforesaid, it is specifically recorded that it remains my duty to ensure that all accounts are received by the medical aid scheme timeously. The Practice nor its agent shall incur any liability in instances where accounts are not submitted to the medical aid scheme timeously;
6. choose *domicilium citandi et executandi* at my physical address overleaf;
7. authorise the Practice, or it's agents, to provide information concerning the patient's treatment and/or medication to the patient's medical aid scheme, managed health care organisation or insurer and their respective agents and employees dealing therewith. Should any of the aforementioned parties also be the patient's employer, then I understand that the information may also be made available to the patient's employer,
8. acknowledge that a certificate
   - 8.1 signed by any doctor of the Practice shall be *prima facie* proof of the patient's indebtedness to the Practice;
   - 8.2 signed by any manager of the Practice's bankers (whose appointment need not be proved) shall be *prima facie* proof of the interest rate referred to in 2 above;
9. acknowledge that I sign these conditions willingly and without duress and that no warranties or representations have been made by the Practice or any of its employees regarding the content hereof;
10. acknowledge that these conditions shall apply to all medication and services rendered or to be rendered by the Practice to the patient until cancelled by me in writing under the Practice's signed acceptance.

VOORWAARDES VIR DIENS

Ek die ondergetekende, die pasient, wettige voog of waarborggewer van die pasiënt op die keersy hierby:

1. onderneem as hoofskuldenaar, alternatiewelik bind ek myself gesamentlik en/of afsonderlik met die pasiënt, vir die betaling van enige eis van die Praktyk wat mag voortvloei uit medikasie en/of dienste gelewer of gelewer staan te word aan sodanige pasiënt, nieteenstaande die bestaan van `n mediese fonds of versekering wat die eis nie mag dek nie;
2. neem kennis dat alle rekeninge teen die lewering daarvan betaalbaar is, en indien die bedrag agterstallig is, sal die bedrag verskuldig rente dra teen die prima oortrekkingskoers sons vasgestel deur die Praktyk se bank van tyd tot tyd;
3. onderneem om, indien die rekening om enige rede onvereffen is en na prokureurs verwys word vir invordering, gesamentlik en afsonderlik aanspreeklik te wees vir die betaling van alle koste op `n prokureur-en-eiekliënt skaal, alle invorderingskommissie en alle opsporingskoste. Alle uitstaande bedrae sal in die volgende volgorde ingevorder word: prokureursfooie, invorderingskommissie, opsporingskoste, rente en laastens kapitaal;
4. waarborg, indien van toepassing, hiermee dat:
   - 4.1. ek `n *bona fide* lid van die genoemde mediese hulpskema is;
   - 4.2. die pasient 'n *bona fide* lid/afhanklike is;
   - 4.3. daar voordeelfondse beskikbaar is vir sodanige pasiënt;
   - 4.4. ek nie gesekwestreer en nie onderhewig is aan enige wetlike of kontraktuele vermoënsgebrek nie;
   - 4.5. die informasie, soos uiteengesit op die keersy hierby, korrek is;
5. magtig die Praktyk of agent van die Praktyk om enige rekening verskuldig deur die pasiënt aan die genoemde hulpskema voor te lê vir betaling. Desnieteenstaande die voorafgaande word daar spesifiek bepaal dat dit my uitsluitlike plig is om die rekening tydig by die mediese fonds in te dien. Die Praktyk of sy agent sal geen aanspreeklikheid aanvaar in gevalle waar rekeninge nie tydig by die mediese fonds ingedien is nie;
6. kies *domicilium citandi et executandi* te my fisiese adres soos op die keersy hiervan aangedui;
7. magtig die Praktyk, of sy agente, om informasie aangaande die pasiënt se behandeling en/of medikasie aan die pasiënt se mediese hulpskema, bestuurde gesondheidsorg-organisasie of versekeraar te verskaf en hulle agente en werknemers wat daarmee handel. Indien enige van die voorafgenoemde partye ook die pasiënt se werkgewer is, dan verstaan ek dat die informasie ook beskikbaar gestel mag word aan die patiënt se werkgewer.
8. erken dat `n sertifikaat:
   - 8.1. geteken deur enige dokter van die Praktyk sal *prima facie* bewys wees van die pasiënt se verpligting teenoor die Praktyk;
   - 8.2. geteken deur enige bestuurder van die Praktyk se bankiers (wie se aanstelling nie bewys hoef te word me) *prima facie* bewys sal wees van die rentekoers waarna verwys in 2 hierbo;
9. erken dat ek hierdie voorwaardes vrywillig en sonder enige dwang onderteken het en bevestig dat daar geen waarborge of voorstellings gemaak is deur die Praktyk of enige van sy werknemers aangaande die inhoud hiervan me;
10. erken dat hierdie voorwaardes van toepassing sal wees op alle medikasie en/of dienste gelewer of wat gelewer staan te word deur die Praktyk aan die pasiënt todat skriftelik gekanselleer deur my onder die Praktyk se getekende ontvangserkenning.

PATIENT/GUARDIAN/
ON BEHALF OF THE PATIENT .....

PASIËNT/VOOG/
NAMENS PASIËNT .....

PLEASE PRINT
NAME HERE .....

NAAM IN
DRUKSKRIF .....

GUARANTOR .....

BORG .....

PLEASE PRINT
NAME HERE .....

NAAM IN
DRUKSKRIF .....

DATE AND TIME .....

DATUM EN TYD .....

RECEPTIONIST.....

ONTVANGSPERSOON.....

I am personally responsible for payment and not my medical aid. 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 including admin costs and a 20% admin fee on each installment paid. If the matter is defended, I will be liable for legal costs incurred on an attorney/client scale. The policy of the operation of this practice has been explained to me verbally. Once my account has been handed over there will be no further correspondence entered into with the practice. All correspondence will be with Absolute Debt Solutions or LEXMED. The National Credit Act 34 of 2005 is not applicable to this claim.

I, the undersigned, hereby choose the stated address as my domicilium citandi et executandi for all purposes under this agreement. I HAVE READ, UNDERSTAND AND AGREE TO THE CONDITIONS MENTIONED ABOVE. I CONFIRM THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT.

Signed/Geteken:

Date/Datum: