CHRISTIAN OLIVIER

B.TECH POD (SA)
PRACTICE NO.0188077

PATIENT DETAILS
Surname:
Full Name:
Title:
D.O.B:
ID Number:
Home Address
Post Code:
Work Address:
Post Code:
Tel: (H) (W)
Cell Phone:
Email:

MEDICAL AID DETAILS
Gap Cover: Y ☐ N ☐
Medical Aid:
Plan:
Medical Aid Number:
Patient Dependant Code:

HOW DID YOU GET TO HEAR ABOUT US?
Referred By (word of mouth/internet):
Or, GP Name:
Telephone:
Email:

MEDICAL HISTORY					
	YES/NO			YES/NO	
DIABETES			KIDNEY DISEASE		
EPILEPSY			HIGH BLOOD PRESSURE		
HEART DISEASE			ASTHMA		
LIVER DISEASE			RHEUMATIC DISEASE		
GOUT			ARTHRITIS		
ARE YOU TAKING A SOCIAL DRUG/NARCOTICS?			ANTI-COAGULANTS (BLOOD THINNING AGENTS)		

ARE YOU ALLERGIC TO:	YES/NO			YES/NO	
LOCAL ANAESTHETIC?			PENICILLIN		
IODINE			PLASTER		
OTHER					

MEDICAL AID MAIN MEMBER
Full Name:
ID Number:
Address:
Post Code:
Occupation:
Employer:
Home Phone:
Work Phone
Cell Phone:
Email:

FRIEND/RELATIVE AT A DIFFERENT ADDRESS
Name:
Surname:
Relationship to Patient:
Address:
Post Code:
Tel: (H) (W)
Cell Phone:
Email:

PRACTICE GUIDELINES

- **This practice is a private practice.**
- **Accounts to be settled on the day of consultation, unless prior arrangements are discussed.**
- **Credit Card facilities are available.**
- **When it comes to inserts (Orthotics), a lab fee will be required upfront before going ahead with the orthotics.**
- **Length of consultations are either 15 minutes, 30 minutes or 60 minutes.**
- **Appointments not cancelled 24 hours in advance or late arrivals will be charged in full**
- **Kindly discuss any queries with Mr Christian Olivier.**

• 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. The National Credit Act 34 of 2005 is not applicable to this claim.

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

Signed/Geteken: _____ Date/Datum:_____

P.T.O

PRACTICE GUIDELINES

PATIENT TERMS AND CONDITIONS

Please read this agreement carefully, and sign if you fully AGREE & 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,
- 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;
- 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 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.
- the disclosure of relevant medical information to my Medical Aid - will typically include diagnoses & ICD10 codes.
- the practice to have 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.**

MEDICAL CERTIFICATES ('SICK NOTE')

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 obligation 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.

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 copy these terms and conditions.
- 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.

PASIËNT TERME EN VOORWAARDES

Lees asseblief hierdie ooreenkoms noukeurig en teken as jy dit heeltemal verstaan en met hierdie terme en voorwaardes saamstem.

INGELIGTE TOESTEMMING

Ek verstaan dat ek die reg het om my dokter te vra om die mediese prosedure en behandeling aan my te verduidelik voordat ek instem tot enige mediese prosedure of behandeling, insluitend die volgende:

- die verskillende behandeling-opsies wat vir my beskikbaar is;
- die algemene en ernstige newe-effekte van 'n spesifieke behandeling;
- die voordele, risiko's, koste en gevolge wat verband hou met elke opsie;
- besonderhede van die diagnose en prognose, en 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 her-evalueer sal word;
- die naam van die dokter wie verantwoordelik vir die behandeling sal wees;
- dat ek die reg het om 'n tweede opinie te enige tyd in te win.

GENERIESE MEDISYNE

Ek verstaan en erken dat my mediese skema kan aandring dat ek medisyne wat op my voorskrif verskyn met 'n generiese ekwivalent vervang. Dit is my dokter se alleenreg om nie toe te laat dat generiese vervanging van my medisyne plaasvind wanneer die dokter op my voorskrif geskryf het: "Geen generiese vervanging".

MEDIESE INLIGTING

Ek magtig:

- 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 diagnoses & ICD10 kodes sal insluit.
- die praktyk om toegang te hê tot my hospitaal rekords, 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 magtiging te eniger tyd skriftelik kan herroep.
My pasiënt inligting kan deur hierdie praktyk openbaar gemaak word op spesiale versoek deur 'n wetstoepassingsagentskap, dagvaarding, hofbevel, of die wet.

BETALING VAN MEDIESE KOSTE

Ek erken dat:

- **ek ingelig is dat hierdie praktyk nie noodwendig die tariewe hef soos deur my mediese fonds bepaal.**
- **my Mediese Fonds nie noodwendig al die fooie betaal wat deur hierdie praktyk gehef word nie.**
- **ek ten volle verantwoordelik is vir die betaling en sou ek nie betyds betaal nie, ek aanspreeklik gehou sal word vir die skuld insameling en regskoste daaraan verbonde.**

MEDIESE SERTIFIKATE ('SIEK NOTA")

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

ALGEMEEN

- ek bevestig dat :
- ek hierdie praktyk vrylik gekies het om mee te raadpleeg.
- ek bewus is dat my dokter oor die algemeen slegs beskikbaar is gedurende kantoorure en raadgewende tye.
- ek verpligtig is om die praktyk in te lig van veranderinge m.b.t. my persoonlike, mediese en/of finansiële inligting.
- ek verstaan hiermee dat my dokter die reg het om sy/haar opinie oor 'n mediese besluit te enige tyd kan verander.
- ek het 'n geleentheid om hierdie terme en voorwaardes te hersien en dat hierdie vorm my wense weerspieël.
- ek elkeen van die terme en voorwaardes gelees 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 vrywillig onderteken.
- ek ingelig is dat, indien my mediese skema nie die rekening van die praktyk ten volle vereffen nie, ek hiermee instem dat die praktyk gemagtig is om namens my my mediese skema aan te gee by die Raad vir Mediese Skemas.

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

Signature: Date:
Handtekening ..... Datum .....