WATERFALL SOS SPORTS MEDICINE

◆ Netcare Waterfall City Hospital ◆ 3rd Floor, Suite 301 ◆ Cnr Magwa Crescent & Simlak Ave ◆ Midrand ◆ 1683 ◆ Tel 011 304 7723

DR J VAN ZUYDAM PR NO: **0397342**

DR J PATRICIOS PR NO: **1537644**

Please print in CAPITALS & Complete both sides

DATE

PATIENT INFORMATION

ID NUMBER (OR PASSPORT NUMBER)	TITLE	FIRST NAMES	
INITALS	LAST NAME	DOB (DAY/MO/YR)	GENDER

CONTACT DETAILS

EMAIL ADDRESS	MOBILE PH	HOME PH	WORK PH
NEXT OF KIN (& RELATIONSHIP eg. wife, sister etc)	NEXT OF KIN CONTACT NUMBER		
STREET ADDRESS	POSTAL ADDRESS		

MEDICAL AID INFORMATION -If the *patient* is the main member, only complete Med Aid Info *

MAIN MEMBER ID NUMBER	PT DEPENDANT CODE	MEDICAL AID NAME *	OPTION/ PLAN *
MEDICAL AID NUMBER *	MAIN MEMBER TITLE	MAIN MEMBER FIRST NAMES	
MAIN MEMBER LAST NAME	MAIN MEMBER MOBILE PH	MAIN MEMBER EMAIL	

REFERRAL INFORMATION

REFERRED BY: TITLE:	**FIRST NAME:**	**LAST NAME:**
EMAIL ADDRESS		
WORK PH	MOBILE PH	
Other relevant information:		

INFORMED CONSENT

I, ……., the undersigned, understand and declare the following:

1. CONSENT TO MEDICAL TREATMENT
    a. During the treatment and evaluation, I might need to uncover specific body parts, and understand that I may refuse to do so if and when I feel uncomfortable in doing so.
    b. The practitioner will need to touch me in order to complete the examination, and I will inform the doctor if and when I feel uncomfortable in doing so
    c. I have been informed of all the benefits and risks of the procedures and/or modalities. I have been informed of alternative procedures and modalities
    d. I understand the procedures and possible potential complications and I have had the opportunity to discuss this with the doctor.

2. CONSENT TO FINANCIAL RESPONSIBILITY OF ACCOUNT
    a. I accept full financial responsibility for the practitioner's account until it is settled in full
    b. I hereby declare that the billing procedures of this practice have been discussed with me, and that I understand the conditions and implications thereof
    c. I understand that payment for the treatment must be made after every consultation. The account is paid in full by me on the day, and then claimed back by me from the medical aid
    d. I understand that I need to cancel an appointment at least 24 hours in advance. I understand that the full treatment amount may be charged for appointments not kept
    e. I understand that if the account remains unpaid after a period of 120 days, the account will be handed over to an attorney for collection. I understand that I will then be responsible for all legal fees incurred.

3. CONSENT TO THE RELEASE OF INFORMATION
    a. I am aware that **Waterfall SOS Sports Medicine** makes use of EVE Systems (Pty) Ltd., and online billing and medical records system. I understand that **Waterfall SOS Sports Medicine** confirmed that my health records will be treated as confidential and in a manner which is in line with relevant legislation. More information on EVE is available on enquiry.
    b. I give consent to **Waterfall SOS Sports Medicine** to disclose information regarding my diagnosis (ICD 10 codes), medical condition, prognosis, treatment compliance and treatment program to the following people/ institutions for the purpose of reporting, referral or settlement of the account. This includes the Medical Aid, referring doctor, employer, lawyer, school, other medical practitioners, parents, children and coach.
    c. I indemnify **Waterfall SOS Sports Medicine** from any liability, damages or whatsoever that I may suffer as a result of this disclosure, and declare that I will hold the aforementioned harmless of any further disclosures and prejudice which I may suffer as a result of such disclosures.
    d. I am also aware that I may have access to my medical information in terms of the provisions of The Promotion of Access to Information Act, and its Regulations. It is further known to me that I can at any time, withdraw this consent and that my personal and medical information will thereafter not be processed other than for payment purposes for treatment/ services rendered. I give this consent freely and declare that it was not made under duress.

Print full name: …….

Signed: …….. Date: …….