SPECIALIST PHYSICIAN AND ENDOCRINOLOGIST

DR JOCELYN HELLIG

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PATIENT – PRACTICE CONTRACT
GENERAL TERMS AND CONDITIONS

Dear Valued Patient

This document explains the general conditions under which this practice sees patients. It constitutes an informed consent to any specific treatment received, but does not constitute a quotation or price for any service rendered by the practice. Informed consent and / or price information can be provided each time you visit the practice and will depend on the care you need / seek, and other factors such as your medical scheme cover. This serves as a binding contract between you, the patient, and the practice. For patients 18 years and older registered as dependants on a medical aid, a separate patient-practice contract with an individual signature may be required. Failing the completion of such a separate contract, the signatory of this contract accepts full responsibility of all beneficiaries on his / her medical aid.

YOUR HEALTHCARE IS IMPORTANT TO US

You hereby provide consent for the exchange of personal and clinical information between all relevant or referred healthcare professionals, medical schemes, and their administrators or appointed managed care organisations.
Under the provisions of The Children's Act, children may consent to certain medical treatment from the age of 12 years. Parents / guardians are however required by law to cover the expenses incurred for the healthcare of their children.

WHAT DOES YOUR MEDICAL AID COVER?

Your treatment, healthcare costs, and quality of your professional care can be severely affected by the type of medical plan you belong to. It remains your responsibility to familiarise yourself with the benefits and terms and conditions associated with your chosen medical aid benefit option. Ascertain the exact amounts your scheme provides for, in terms of consultations, procedures and treatments as well as what your medical aid will cover. Where a designated service provider has been appointed by your medical aid, it remains your responsibility as the patient to familiarise yourself with any medical and financial restrictions when consulting a non-designated service provider.
With increasing interventions from your medical scheme, please be aware that the practice will not allow the medical scheme to violate the healthcare professional's clinical independence. Where a medical aid or its advisors intervene to overrule your healthcare professional's preferred diagnostic approach or treatment, your healthcare professional accepts no responsibility for consequent adverse outcomes. You may be requested to allocate responsibility to the medical aid and its medical advisors in the event of adverse treatment outcomes. You remain responsible for any amount that your medical scheme or Funder does not pay for any services rendered and invoiced for, by the practice.

PRE-AUTHORISATIONS

If pre-authorisation is required for any medical procedure or treatment, it remains your responsibility to ensure that the planned treatment is covered by your medical aid. It is also imperative to ensure that the necessary finances are put in place to cover the non-insured costs. It remains your responsibility to furnish the practice with the relevant information and authorisation numbers. If the medical aid will not cover all costs, you undertake to pay any amount that is not covered by your medical aid. Where your medical aid questions any aspect of your treatment, your healthcare professional may submit a letter of motivation to the medical aid and insist on a peer-to-peer discussion if appropriate

SETTLING OF ACCOUNTS AND CO-PAYMENTS

The practice staff will inform you should the practice have any arrangements in place with your medical aid.
The practice reserves the right to claim directly from you in which case you will be provided with a detailed invoice that is payable within 30 days from date of service. You have the option to claim this back from your medical aid should you wish to do so.
Please take note of this practices' billing policy in relation to costs for services rendered. Where an exact price cannot be presented, a quotation could be provided, subject to its own terms and conditions. Due to the billing policy, a co-payment may be levied by the medical aid or the practice. Such charges above the medical aid policy coverage, will be payable by you. You (or your parent / guardian) remain liable for the account at all times, for services rendered by the practice even if you are covered by a medical aid or any other third party. This contract does not prevent the practice from taking all reasonable and practical steps to recover any outstanding amounts from any obligated party. You hereby consent that your personal information may be provided to attorneys or debt recovery agencies to recover from you any amounts due if they remain unpaid. The practice reserves the right to charge interest on your outstanding account that is due from date of service up to maximum interest allowed in the National Credit Act No. 34 of 2005 ("NCA").
It remains your responsibility to inform and update all personal and medical aid information with the practice and to keep the practice regularly informed with regard to any changes on your contact details, benefits and list of dependants. Please note that the use of someone else's medical aid card with or without such a person's consent or knowledge, constitutes fraud. The practice will report such instances to the medical aid concerned to protect the practice from being regarded as a cooperative in committing fraud.
The practice reserves the right to charge a service fee for any credit given in terms of the provisions of the NCA.

SICK CERTIFICATES

The practice will only provide sick certificates should the specific condition warrant such a certificate. If a diagnosis is

provided on the sick certificate, the certificate will be handed only to you, unless otherwise specified by you in writing. Discretion in disclosing your condition or diagnosis to your employer remains with you. If you or your employer considers claiming for a disability, you may be required to disclose the nature and extent of such a disability to your employer, insurance company and / or other third party, where applicable.

CONFIDENTIALITY, POPIA and DATA RETENTION

All information handled by the practice is regarded and treated as strictly confidential by the healthcare professional and the practice staff. Legislation compels the practice to provide certain information on accounts, including diagnostic information. Failure to submit the correct codes might lead to the claim being incorrectly paid or rejected by your medical scheme of funder.

The Practice must also disclose ICD-10 codes on referral letters, requests for special investigations (e.g. radiology, pathology) etc.

In the event of a third-party request for confidential information from the practice, and in doubt regarding the safety of confidentiality processes, the practice may insist on following the standard operating procedures legislated in any legislation.

You hereby consent in terms of the Protection of Personal Information Act 4 of 2013 ("POPIA") as amended from time to time, that the practice may share your personal information (including diagnostic information) for practice administration services, including external practice administration providers contracted by the practice, historical, statistical, research purposes, or practice business planning with other service providers to enhance systems and services, this to include sharing with the personal information with other Healthcare Practitioners, Medical Schemes, Claim/Invoice Switch Houses in the course of providing the services to you. Your participation in this regard is highly appreciated.

Your personal Information will be securely retained by the practice for a period of no longer than five (5) years after your last visit to the practice, or as required by legislation if longer than this period.

The Practice shall not transfer or authorise the transfer of Personal Information to countries outside of the Republic of South Africa without your prior written consent (which written consent you hereby provide in terms of section 72(1)(b) of POPIA to allow such transfer outside the Republic of South Africa) for the purposes as defined in the POPIA and specifically to provide the required services to the Practice and to you. If Personal Information processed under this Agreement is transferred from the Republic of South Africa to third party in another country, the transferring Party shall comply with sections 72, 57 and 58 of POPIA. This portion of this Agreement is only applicable to Practices with their Data Subject's PI (your PI) located within the jurisdiction of the POPIA.

You further hereby consent that the Practise may contact you by any one of the following communication methods/platforms/systems ("communications"); namely: phone, sms, Email, social media platforms such as WhatsApp, Telegram, Signal or similar services or any future communications. You understand that these communications will be used for professional communication only. This will include (but not be limited to) accounts, statements and information, practice information, system updates, professional updates, prescriptions and reports where necessary and indicated. You acknowledge that none of these communications are completely secure or encrypted communications, and you will not hold the Practice responsible for any breach of confidentiality via these communications.

Please tick the appropriate box(es):

I understand the implication and agree that, where appropriate, the healthcare professional and practice may disclose my ICD-10 diagnosis code(s) under the conditions described above.

☐

I understand the implications and request that the healthcare professional does not disclose the specifics of my diagnosis. The healthcare professional is to use ICD-10 code U98.0 (Patient refusing to disclose clinical information). In this case I assume full liability for the account in its entirety.

☐

SIGNATURES

I hereby acknowledge that I have read and understood the above information.

I have also been given the opportunity to ask questions prior to having signed this contract and acknowledge that all information submitted by me is true and correct. I understand that I am under continued obligation to advise the practice / healthcare professional of any changes of my information, or consent, or medical condition that may occur after submission of this contract and acknowledge, by signing this contract, that I am legally bound by the provisions of the contract.

Billing Policy

Please note that this practice does not charge medical aid rates. Patients are encouraged to contact the practice prior to receiving treatment in order to obtain any rates. All out of hospital consultations / services are payable upfront on the day of the consultation/service.

_____

Patient / Main Member / Parent / Guardian name

_____

Patient / Main Member / Parent / Guardian ID Number

_____

Patient/Main Member/Parent/Guardian Signature

_____

Date of Signature

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Patient Particulars Form

PATIENT

ID or Passport Number _____ Passport Country _____
Title _____ Date of Birth _____
Initials _____ Gender _____
Surname _____ Occupation _____
First Name _____ Employer _____

CONTACT

Cellular _____ Home Phone _____
Work Phone _____ E-mail Address _____
Residential Address _____
_____ Postal Code _____
Postal Address _____
_____ Postal Code _____

MEDICAL AID

Medical Scheme _____
Plan / Option _____
Membership Number _____
Dependent Code _____

EMERGENCY CONTACT

Name and Surname _____
Phone _____
Relationship to patient _____

MAIN MEMBER

Patient is Main Member ☐ (if yes, then you may skip this section)
ID or Passport Number _____ Passport Country _____
Initials _____ Phone _____
Title _____ E-mail Address _____
Surname _____ Employer _____
First Name _____ Employer Phone _____
Relationship to patient _____
Residential Address _____
_____ Postal Code _____
Postal Address _____
_____ Postal Code _____

PERSON RESPONSIBLE FOR PAYMENT

Patient is Guarantor ☐ (if yes, then you may skip this section)
Main Member is Guarantor ☐ (if yes, then you may skip this section)
ID or Passport Number _____ Passport Country _____
Initials _____ Phone _____
Title _____ E-mail Address _____
Surname _____ Employer _____
First Name _____ Employer Phone _____
Relationship to patient _____
Residential Address _____
_____ Postal Code _____
Postal Address _____
_____ Postal Code _____

OTHER

Referred By _____
Referrer Phone _____
Family Doctor _____
Family Doctor Phone _____

CONSENT

I hereby give consent for my information to be shared by this practice and any 3rd parties deemed necessary for my care
Signed by _____ on _____
at _____ _____

_____ _____ _____
Patient Name & Surname Patient / Guardian Signature Date