dr hester van der walt

mb chb (us) dkg/dch mmed (ped/paed) (ovs/ofs)

weskus pediatrie / west coast paediatrics

this practice is POPIA and PAIA compliant
21 voortrekker str, vredenburg, 7380; tel 0227135149, fax per email, admin@pediater.co.za, www.pediater.co.za
pr 0377597, mp 0279102, sama 11741, vat 4530258856, registration 2013/207395/21

PATIENT TERMS AND CONDITIONS

Please read this agreement carefully, and sign if you fully AGREE WITH & UNDERSTAND

INFORMED CONSENT

PERSONAL INFORMATION PROVIDED IN THIS CONTRACT WILL BE TREATED ACCORDING TO THE PROTECTION OF PERSONAL INFORMATION ACT 4 OF 2013 AND OTHER ACTS, CODES AND REGULATIONS GOVERNING THE HEALTHCARE PROFESSION (FOR INSTANCE) AND MUST BE READ WITH OUR PRIVACY POLICY

I, [full names and surname, print please!].....
an adult person (18 years or older) / the parent or legal guardian of a child younger than 12 years of age / a child 12 years or older (delete what is not applicable) hereby authorise, freely and voluntarily and with knowledge of the implications of such consent, the Practice to disclose the specific information outlined herein to the entities / person(s) mentioned and to the extent identified herein.
I also herewith declare that I am personally responsible for all financial consequences of services rendered to the patient by the Practice.
My relationship to the patient / entity whose information I give is :

.....
I AM LEGALLY ENTITLED TO PROVIDE THE INFORMATION IN THIS DOCUMENT

1. I consent that information about the patient as given here as well as further diagnoses may be disclosed to or enclosed in reports to other persons registered with the Health Practitioners Council of SA with the aim of providing the patient with necessary follow-up care or treatment.

2. I also consent to the sharing of the patients personal information as provided by me and generated in the course of necessary medical procedures/diagnoses with the understanding that such processing of information shall be legal and minimal with:

1. Another person such as a parent / guardian / authorized person sitting in at the consultation or procedure. Such a person would then hear and/or see information that would otherwise remain confidential between the patient and healthcare practitioner.
2. Another person such as a parent / guardian / authorized person receiving updates on how the patient is doing before, during and/or after a procedure or treatment, when in hospital / ICU, etc.
3. Another person such as a parent / guardian / authorized person or entity who can get a copy of specific health records like a copy of the patient's file, a medical report, a copy of a sick certificate, prescription, etc.
4. Another person such as a parent / guardian / authorized person or entity who can consent to treatment and care when the signatory cannot, can receive information about the patient which will enable them to make a decision.
5. Another person such as a parent / guardian / authorized person or entity or school be informed of specific aspects, e.g. the nature of the patient's illness, how long s/he would be away and why, etc. The signatory takes sole responsibility for any consequence that may flow from a disclosure of personal information to an employer or school.
6. An insurance company, which requires the completion of forms, and/or the drafting of a report.
7. A pharmaceutical or medical device company, to which details of a negative event associated with a product must be shared.
8. A medico-legal report.
9. A report constituting a second opinion.
10. A report to an attorney or information which by any law must be released to the State or another legal authority - as in cases of infectious diseases.
11. Accounts and reports containing data such as the ICD-10 diagnostic codes to Medical Aid Schemes or other POPIA compliant entities for the processing of accounts where this is applicable.

3. CONSENT REGARDING GENERIC MEDICINE

1. I understand and acknowledge that my Medical Scheme may insist that I substitute medicine that appears on the patients prescription with its generic equivalent. It is within my doctor's sole discretion whether or not to allow for the generic substitution of the medicine and no prescription substitution may take place where the doctor has written 'no generic substitution' on the prescription

4. CONSENT TO DISCLOSURE OF MEDICAL AND PERSONAL INFORMATION

I further consent:

1. that a copy of the patients medical record will be kept by this practice doctor on file.
2. the disclosure of relevant medical information to my Medical Aid or Medical Insurance/assurance.
3. the disclosure of relevant treatment codes to organisations to facilitate reimbursements.
4. the practice to have access to my - the patients - hospital records, radiology and laboratory results.

In cases where consent is given above but needs special and specific written consent in terms of inter alia POPIA such written consent will be obtained from the legal guardian or responsible person in the legally prescribed manner.

SLEGS DEUR JESUS CHRISTUS!

signatory to initialize

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5. I understand that I have the right to ask the doctor to explain and disclose medical information to me before I agree to a medical procedure or treatment, including the following:

1. different treatment options available,
2. common and serious side effects of specific treatment options,
3. the benefits, risks, costs and consequences associated with each option;
4. details of the diagnosis and prognosis, and the likely prognosis if the condition is left untreated;
5. any uncertainties regarding the diagnosis;
6. how and when the condition and any side effects will be monitored or reassessed;
7. the name of the doctor who will have overall responsibility for the treatment;
8. that I have the right to seek a second opinion at any time.

6. PRIVACY AND PROCESSING OF PERSONAL INFORMATION UNDER POPIA AND PAIA

You have the right to:

1. Request which data we have on the patient or yourself
2. Request to change or amend patient data or your own
3. Request patient data or your own to be erased/deleted

7. PAYMENT OF MEDICAL COSTS

I acknowledge that:

1. I have been informed that this practice does not necessarily charge the rates Medical Aids may have decided upon.
2. My Medical Aid may or may not cover all the fees charged by this practice.
3. **I am fully responsible for payment and should I not pay timeously, I will be liable for debt recovery & legal costs.**
4. **Should my Medical Aid not cover the services rendered or my Medical Aid benefits are depleted or if I am a private patient, I will settle my account before leaving the Practice or make a payment arrangement.**

8. MEDICAL CERTIFICATES ('SICK NOTE')

I hereby acknowledge that I understand that although I am entitled to ask for a medical certificate from my doctor, she is under no obligation to issue such a certificate. If such a certificate is issued the patients diagnosis can be disclosed on the certificate provided I have given my consent, the decision who I want to show the certificate to is my decision.

9. PRE-AUTHORISATION

I am fully aware that if a procedure requires hospitalization, I am responsible to ensure that my Medical Aid provides the required permission and covers the financial cost of the procedure BEFORE the patient undergoes the procedure. My Medical Aid may contact the doctor to discuss the need, or to ask for a motivation, for the procedure and I accept responsibility for all costs involved and give consent that the necessary personal information of the patient may be disclosed.

10. GENERAL

I hereby confirm that:

1. I have freely chosen this practice to consult with.
2. I am aware of the fact that the availability of my doctor is generally limited to office hours and consulting times.
3. **I am under the obligation to inform the practice of changes to my personal, medical and/or financial information.**
4. I hereby understand that my doctor has the right to change her mind about a medical decision at any time.
5. I have had an opportunity to review these terms and conditions and that this form accurately reflects my wishes.
6. **I have read and understand each of the terms and conditions contained in this agreement.**
7. I have a right to inspect and/or copy these terms and conditions - **this form is also on the web site www.pediater.co.za.**
8. **I am signing these terms and conditions voluntarily.**
9. **I am aware that telephonic/electronic consultations or advice may be charged for.**
10. **I am aware that should I not cancel my appointment 24 hours prior to my appointment time, I may be charged the full consultation fee.**
11. **I take note of and consent to the fact that the registration number of the vehicle I used to enter these premises as well as images of me and those persons with me are on record by means of CCTV cameras. This data is for security reasons and is destroyed on a regular basis if not otherwise used as legally prescribed.**

SLEGS DEUR JESUS CHRISTUS!

signatory to initialize

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THIS IS A LEGAL AND BINDING CONTRACT, PLEASE WRITE LEGIBLE AND ENSURE THAT THIS INFORMATION IS KEPT UP TO DATE!
HIERDIE IS 'N BINDENDE KONTRAK, SKRYF ASSEBLIEF DUIDELIK EN HOU DIE INLIGTING OP DATUM!

patient (child) detail

surname	**sex**
name	**date of birth (dd/mm/yy)**
id no (if applicable)	**place of birth**

details of parent/guardian or other person legally responsible for patient

this person will be referred to as guardian

first parent/legal guardian/signatory

second parent/legal guardian/signatory

FULL NAMES & SURNAMES

id/passport number/s

indicate by marking with a cross which can be used for sharing patient personal information

		mobile phone		
		alternative contact number		
		fax number		
		email address		
		other, please indicate		

home (street) address AND postal address IF NOT THE SAME

medical aid name (for patient!)

full name principal member		family doctor	
medical aid plan/option		medical aid number	
referring doctor			
dependant code	id of principal member		

I, the undersigned, the custodian/guardian/parent/responsible person of the patient, am personally responsible for payment AND NOT my or any other medical aid, person or institution. In the event of any legal action being instituted against me [the undersigned] for recovery of any amount whatsoever, I shall be liable for all legal costs including administration costs and a 20% administration fee on each instalment paid. If the matter is defended, I will be liable for legal costs incurred on an attorney/client scale. Once my account has been handed over there will be no further correspondence entered into with THIS PRACTICE. Right of admission to the premises of this practice is reserved. I hereby choose my provided home/street address as my *domicilium citandi et executandi* for all purposes under this agreement. I acknowledge that South African Law applies to the relationship between me and THIS PRACTICE.

I take note that all communication entered upon with this practice via social media (Facebook, Twitter, Whatsapp etc), the internet or telephone is at my own risk and THIS PRACTICE and its personnel can not be held accountable for any diagnosis or treatment so done or initiated and or unlawful disclosure of confidential information as the result of such communication.

I HAVE READ, UNDERSTAND AND AGREE TO THE CONDITIONS MENTIONED ABOVE, I CONFIRM THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT AND THAT

I MAY BE CONTACTED ON MY PHONE NUMBER OR MY E-MAIL ADDRESS AS PROVIDED ABOVE.

Signature

Full names, please print

Date and Place

SLEGS DEUR JESUS CHRISTUS!