KRUGERSDORP GEHOORSENTRUM

311 Jorrisen street
MONUMENT
Krugersdorp, 1742

Oudioloog:
Dr. E de Koker
Epos: riana@hearcare.co.za

Tel: 011 660 5080
Praktyk Nr: 8212910

PASIËNT BESONDERHEDE/PATIENT INFO

Surname VAN	Full name/s VOLLE NAME
Mr/Mrs/Miss TITEL	Date of Birth/ID number GEBOORTE DATUM /ID NOMMER
Dependent Code AFHANKLIKHEIDSKODE BY FONDS	Sex GESLAG

HOOFLID REKENING BESONDERHEDE/MAIN MEMBER INFO
(Persoon verantwoordelik vir rekening)(Person responsible for account)

VAN /Surname	VOLLE NAME /Full names
TITEL/Title	ID NR:
POSADRES/Postal address	FISIESE ADRES /Physical address
E-POS ADRES HOOFLID/Email address main member	E-POS ADRES PASIËNT/Email address patient
WERK TEL NO HOOFLID/Work tel – main member	HUIS TEL NO HOOFLID/Home tel no – main member
SEL NO HOOFLID/Cell no – main member	SEL NO PASIËNT / Cell no - patient
MEDIESE FONDS/Medical Aid	MEDIESE FONDS NO/Medical aid no
MEDIESE FONDS PLAN /Medical aid plan	
NAASBESTAANDE: (nie woonagtig by u)/Next of kin	NAASBESTAANDE TEL NO/next of kin tel no
HUISDOKTER / Doctor	VERWYSENDE DOKTER /Referred by
WAAR HET U VAN ONS GEHOOR?/ how do you know about us?	

Hiermee verklaar ek dat die bogenoemde inligting korrek is en dat ek die praktyk in kennis sal stel sou enige van my kontak besonderhede verander./ I, declare that the information given above is correct and that I will notify the practice immediately should there be any changes to the details.

_____ _____ _____

Handtekening /Signature **Volle Name en Van/Name in full** **Datum/Date**

TERME EN VOORWAARDES

DEUR HIERDIE VORM TE TEKEN AANVAAR DIE ONDERTEKENDE DIE PRAKTYK SE VOORWAARDES EN GEE TOESTEMMING VIR BEHANDELING SOOS HIER ONDER UITEENGESIT:

- Hiermee gee ek toestemming vir behandeling / toetsing van enige personeellid wat geregistreer is met die HPCSA binne die omvang van die beroep as oudioloog. Behandeling sal vooraf met die pasient bespreek word asook veranderinge in die behandelingsplan. Ek is bewus daarvan dat my keuse is om behandeling te ontvang en hiermee toestemming tot behandeling gee. Ek kan ook behandeling op enige tydstip staak indien ek wil.
- Ek is bewus van die belang van konfidensialiteit van my behandeling, maar gee die oudioloog toestemming om die diagnose, verslae en kliniese notas aan die mediesefonds, verwysende dokter en ander relevante personeel beskikbaar te stel soos nodig vir effektiewe behandeling en opvolg.
- Ek is bewus daarvan dat alle konsultasies en sessies gedokumenteer word vir mediese hersienning en rekorddoeleindes.
- Hiermee neem ek kennins van die volgende terme en voorwaardes in verband met my rekening en/of dienste gelewer aan my deur hierdie praktyk:
  - Ek gee toestemming dat my rekeningstaat diagnostiese en prosedurekodes mag bevat sodat dit ‘n volledige en akkurate weerspieeling van my behandelingreflekteer;
  - **Ek besef dat my rekening binne 60 dae vereffen moet word en dat ek ten alle tye verantwoordelik bly vir die uitstaande bedrag;**
  - Ek is bewus daarvan dat alhoewel daar vooraf magtiging vir behandeling en/of gehoorapparate verkry kan word deur die praktyk, dit nie ‘n waarborg van betaling van my mediesefonds is nie en dat ek steeds verantwoordelik bly vir die rekening indien die mediesefonds nie die rekening betaal nie;
  - Ek is bewus daarvan dat dit my verantwoordelikheid bly om bewus te wees van beskikbare fondse by my mediesefonds vir behandeling en/of gehoorapparate en om die praktyk in kennis te stel indien daar nie genoegsame fondse beskikbaar is nie;
  - Ek is die hooflid van die mediesefonds of ek het toestemming van die hooflid gekry om die mediesefonds te mag gebruik al dan nie;
  - Pasiente onder 18 jaar: Ek is die pasient se ouer of wettige voog of ek het die ouer of wettige voog se toestemming om die pasient te vergesel na die afspraak/behandeling en ek mag namens die pasient hierdie toestemmingsvorm teken;
  - Alle moontlike stappe word gevolg om rekeninge betyds en akkuraat na die mediesefonds te stuur, maar onder geen omstandighede kan hierdie praktyk verantwoordelik gehou word vir rekeninge wat deur die mediesefonds verwerp word vir enige rede nie;
  - Ek aanvaar verantwoordelikheid vir alle prokureurs- en/of insamelingskostes wat aangegaan moet word deur die praktyk indien my rekening vir skuldinsameling oorhandig word;
  - Ek verstaan en aanvaar dat my rekening onder hewig is aan die maksimum voorgeskrewe rentekoers, maandeliks bepaal op uitstaande rekeninge ouer as 60 dae, soos uiteengesit in die Nationale Kredietwet Nr 34 van 2005, van tyd tot tyd.
  - **Indien ek nie my afspraak ten minste twee ure vooraf kanselleer nie of net nie opdaag vir my afspraak nie, mag ‘n konsultasiefooi vir my persoonlike rekening gehef word wat ek persoonlik sal betaal sonder dat dit na die mediesefondsa gestuur sal word;**
  - **Indien ek gehoorapparate bestel en dit an bestelling vir enige rede kanselleer, sal daar ‘n kansellasie- en/of hanteringsfooi gehef word waarvoor ek verantwoordelik sal wees selfs al neem ek nie meer die gehoorapparate nie;**
- Ek neem kennis dat hierdie praktyk mediesefonds tariewe gebruik en dat ek geregtig is op ‘n lys van kodes wat gebruik gaan word vir my behandeling. Sou ek hierdie inligting en/of ‘n kwotasie vir behandeling verlang is dit my verantwoordelikheid om dit spesifiek voor behandeling vanaf die oudioloog aan te vra.
- Hiermee neem ek kennis van die onderstaande geraamde kostes van die verskillende behandelingsopsies en gee toestemming dat al die toetse uitgevoer word soos die oudioloog goed dink op grond van my spesifieke gevalsgeskiedenis, simptome en resultate.
- **Ek besef dat ek net kan kwalifiseer vir gratis promosie siftingstoetse indien ek die advertensie/pamflet as bewys saam met hierdie vorm indien.**
- **Indien ek nie wil hê dat die praktyk my rekening namens my na my mediesefonds stuur nie, is dit my verantwoordelikheid om die praktyk in kennis te stel dat die rekeninge nie ingedien moet word nie. Enige rekeninge wat die praktyk nie namens pasiente by ‘n mediesefonds moet indien nie sal kwalifiseer vir ‘n**

10% hanteringsfooi afslag / met kontantbetaling tydens sessie. Gehoorapparaat pryse kan slegs gegee word nadat 'n gehoortoets uitgevoer is.

TERMS AND CONDITIONS

BY SIGNING THIS FORM THE PATIENT ACCEPTS THE PRACTICE'S TERMS AND CONDITIONS AND AGREES TO THE FOLLOWING:

- To be treated by any therapist employed by the practice and who is registered with the HPCSA within the scope of practice. I comprehend that I can stop treatment at any time if I so wish.
- I am aware of the importance of confidentiality regarding my treatment, but hereby give the audiologist permission to share my diagnosis, reports and clinical data with my medical aid, referring doctor and other relevant admin and medical personnel, as needed to ensure effective treatment.
- I am aware that all consultations and sessions are documented for medical review and record keeping purposes.
- I herewith agree to the following terms and conditions regarding my account and/or services rendered to me by this practice:
  - I give permission that my account may contain diagnostic and procedure codes in order to be a complete and accurate reflection of my treatment;
  - **I acknowledge that my account should be settled within 60 days and that I remain responsible for settling my full account;**
  - I am aware of the fact that even though pre-authorization or confirmation of benefits before treatment and/or hearing aid fitting may be obtained by the practice, this is not a guarantee of payment by the medical aid and that I remain responsible for any amount not paid by my medical aid for any reason;
  - I am aware that it is my responsibility to know whether or not I have sufficient funds available in my medical aid to pay for treatment and/or hearing aids and that I must inform the practice if there are insufficient funds available in my medical aid to pay for these services;
  - I am the main member of the medical aid or have the main member's permission to use the medical aid. The practice will under no circumstances confirm whether patients are allowed to use the medical aid;
  - For patients under 18 years; I am the patient's parent or legal guardian and have the parent's permission to accompany the patient to treatment/consultations and may sign this consent form on the patient's behalf;
  - All possible steps will be taken by the practice to ensure that my account is delivered to medical aid accurately and in a timely fashion, however, I realize that under no circumstances may I hold the practice liable for any accounts that are rejected by my medical aid for any reason;
  - I assume responsibility for all lawyer and/or debt collection fees that may be accumulated by the practice if my account is handed over for debt collection due to non-payment.
  - I understand and accept that my account is subject to maximum prescribed interest rate, calculated monthly on overdue accounts exceeding 60 days as set out in the National Credit Act No.34 of 2005, from time to time.
  - **If I do not keep my appointment or cancel the appointment at least two hours before the appointment, I will be responsible for the consultation fee which will be for my personal account and will not be submitted to my medical aid;**
  - **If I order hearing aids and I cancel the order after it has been placed for any reason, I will be held liable for a cancellation and handling fee which will be for my personal account and will not be submitted to my medical aid, even if I do not take the hearing aids.**
- I am aware that this practice uses medical aid tariffs and I am entitled to a list of procedure codes that may be used for my treatment. Should I wish to acquire this list and/or quotation for treatment, it is my responsibility to specifically ask for it from the audiologist before treatment commences;
- I herewith, acknowledge the cost guidelines as set out below for various procedures and give my consent that all tests deemed necessary by the audiologist may be conducted as she sees fit based on my case history, symptoms and test results;
- I acknowledge that I only qualify for a free screening test if I can produce the relevant advertisement or pamphlet together with this signed form;
- **Should I wish to not have the practice submit my account to my medical aid on my behalf, it is my responsibility to specifically request this before treatment in order to ensure the account is not**

submitted. Any account that is not submitted to the medical aid by said practice will qualify for a 10% administrative discount when paid in full by the patient on the day of the consultation. Assistive listening devices can only be given to a patient after a diagnostic hearing test has been conducted.

- **Furthermore, I hereby confirm that I have read and understood the terms and conditions as set out herein.**

Ons wil u graag ingelig hou van die nuutste promosies, produkte, opedae, afslagte en ander belangrike kommunikasie. Deur die boks hieronder te merk gee u vir ons en Beltone (Hearing Innovations) toestemming om u te kontak dmv e-pos en/of SMS. U kan enige tyd hierdie kommunikasie kanselleer.

We would like to keep you updated with all our latest promotions, products, open days, specials, discounts and other important communications. By checking the box below, you give us and Beltone (Hearing Innovations) permission to contact you via e-mail and/or SMS. You can opt out at any given time.

☐ (Please tick) Hearcare

☐ (Please tick) Hearing innovations (Beltone)

_____	_____	_____
Handtekening/Signature	**Volle Name en Van/Name in full**	**Datum/Date**