INFORMED CONSENT

AGREEMENT ENTERED INTO BETWEEN MEDICAL PRACTITIONER AND PATIENT

PARTIES:

Mr/Mrs/Ms_____ (Please give full name), Identity no. _____

(hereinafter referred to as "the patient")

Of (full physical addresses):

1. residence:

_____

_____

_____

2. business:

_____

_____

_____

and

Doctor/representative_____

(hereinafter referred to as "the doctor" and/or "the representative")

of (full physical address of practice):

_____

_____

_____

Practice code no. _____

MP no.:_____

Doctor:

To be completed by Doctor

- ☐ I confirm that I have explained the following to the patient in terms of which, in my judgment, are suited to the understanding of the patient and/or to one of the parents or guardians of the patient.
- ☐ The parties' health and status condition;
- ☐ The range of diagnostic procedures and treatment options generally available to the patient;
- ☐ The benefits, risks, costs and consequences generally associated with each option
- ☐ The patient's right to refuse health services and the implications, risks, and obligations of such refusal;

- ☐ The nature and purpose of the proposed operation, investigation or treatment, namely;

  _____

- ☐ The type of anaesthetic, if any (general/local/sedation) _____
- ☐ The possible need for blood or blood products during and after the procedure and the risks associated with receiving blood or blood products

Signature _____ Date _____

Name of Doctor _____

Patient/Parent/Guardian/Mandated person

To be completed by patient

I, the undersigned, state as follows:

- ☐ I am the patient/parent/guardian;
- ☐ The Doctor named on this form has explained fully to me the issues listed and ticked above;
- ☐ I confirm that I understand everything that has been explained to me, I have also received answers to all my questions and been informed that, if I want more information, I should ask the Doctor;
- ☐ I understand that problem(s) and complications may occur even when the best care, judgment, and skills are used. No guarantees have been made to me by the Doctor;
- ☐ I agree to the operation, investigation or treatment as explained to me, and to the use of the type of products as may be considered necessary and in my6 best interests and can be justified for medical reasons;
- ☐ I have told the doctor that I **DO NOT** want the procedures below to be carried out without having the opportunity to consider them _____
- ☐ I consent to the retention and/or disposal by the health facility and or doctor of any tissue or parts which may require removal;
- ☐ I understand that I may withdraw consent to, or refuse, treatment at any time.

Signature _____ Date _____

Name of Patient/Parent/Guardian _____

Dear Patient,

(Name of Practice) – **Terms and Conditions**

1. In line with SAMA's (South African Medical Association) commitment to a viable and sustainable private health care sector in South Africa, we strive for excellence at all times.
2. This practice does not currently charge levies/currently charges levies. Claims are submitted directly to medical schemes at agreed scheme rates.
3. SAMA strongly recommends "balanced billing". Balanced billing is where you and your scheme receive identical accounts for the services rendered, specifying the portion due by you and the portion due by your scheme. If balanced billing is not applied, SAMA advises "the patient to settle their account in full at the time and point of service and then claim a part of this back from their scheme".
4. It remains the responsibility of the patient/person responsible for payment to pay the account, even if the patient is a member of a medical aid and irrespective of whether or not the medical aid pays the doctor.
5. It remains the responsibility of the patient to ensure their medical aid/insurance is up to date and fully active.
6. We reserve the right to apply "balanced billing" for consultations, repeat prescriptions, telephone consultations, chronic forms etc.
7. It is your responsibility to obtain information from your medical scheme as to the benefits provided by your medical scheme and we will not be held responsible if our treatment plans fall outside your scheme's benefits. We shall however endeavour to assist in every way we can.
8. Patients should take note that it is important to discuss treatment costs and professional fees with their doctors.
9. Normal working hours are _____ Mondays to Fridays, and _____on Saturdays. All other periods are regarded as after hours, including public holidays and will be billed accordingly.
10. According to the National Health Act No 61 of 2003, Section 5, a health care provider may not refuse a person emergency medical treatment. Emergency care however means the "immediate, appropriate & justifiable medical assessment and care required to prevent or limit future impairment to bodily functions and/or to preserve the person's life".
11. This practice does partake/ does not partake in the "medical benefits for compensation for occupational injuries & diseases (COID/WCA)". Please be director to the nearest Hospital Casualty. We also participate/ do not participate in the Road Accident Fund's emergency care.

Cancellation of Appointments

We bill according to the South African Medical Associations' Doctor's Billing Manual of 2009.

Section A: General Medical and Surgical Services, Paragraph D states:

"Unless timely steps are taken to cancel an appointment for a consultation, the relevant consultation fee may be charged. In the case of a general practitioner "timely" shall mean **2 hours** and in the case of a specialist **24 hours prior to the appointment.** Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. If a patient has not turned up for a procedure, each member of the surgical team is entitled to charge for a visit at or away from doctor's room as the case may be."

_____

Signature Patient/Main Member/Guarantor

The private consultation fee for _____ is R _____. Medical aid rates will apply for scheme patients.

Please sign on the back of your file before you leave.

We apologise for waiting times and assure you we strive to give the best care to every one of our patients. We ask for your patient e as we will treat you in the same manner the day you need us.

Your signature on this document serves as written consent that you accept these terms and conditions.

_____ _____

Signature Patient/Main Member/ Guarantor Date