DR. IGNATIUS BOTHA
M.B. Ch.B.(Pret), M.Med.(Chir) Stell.
surgeon-chirurg

PATIENT / PASIËNT [PROF / DR / MNR / MEV / MEJ]		DATE OF BIRTH / GEBOORTE DATUM:	
I.D. NUMBER / I.D. NOMMER:			
SURNAME / VAN:			
NAMES / VOORNAME:			
HOME ADDRESS / WOON ADRES:			
		HOME TEL / HUIS TEL:	
OCCUPATION / BEROEP:			
EMPLOYER / WERKGEWER:			
WORK ADDRESS / WERK ADRES:			
		WORK TEL / WERK TEL:	
		CELLPHONE / SELFOON:	
PERSON RESPONSIBLE FOR ACCOUNT / PERSOON VERANTWOORDELIK VIR REKENING: HOOFLID			
PATIENT / PASIËNT [PROF / DR / MNR / MEV / MEJ]		DATE OF BIRTH / GEBOORTE DATUM:	
I.D. NUMBER / I.D. NOMMER:			
SURNAME / VAN:			
NAMES / VOORNAME:			
POSTAL ADDRESS / POSADRES:			
POSTAL CODE / POSKODE:		HOME TEL / HUIS TEL:	
OCCUPATION / BEROEP:			
EMPLOYER / WERKGEWER:			
WORK ADDRESS / WERK ADRES:			
		WORK TEL / WERK TEL:	
		CELLPHONE / SELFOON:	
MEDICAL AID / MEDIESE FONDS:			
NUMBER / NOMMER:			
HOSPITAL PLAN / HOSPITAAL PLAN:			
REFERRING DR / VERWYSENDE DR:		TEL:	
FAMILY DR / HUIS DR:		TEL:	

210 Panorama Medi Clinic, Rothschild Boulevard, Panorama, 7506, South Africa

DECLARTION / VERKLARING:

I, hereby, agree that;

1. I am personally liable to pay the statement of account for services rendered to me. I agree that the fact that the account may under particular circumstances be recovered directly from a Medical Aid, does not relieve me from obligation to pay this practice on the due date.
2. I am liable for interest on arrear payments should I be in default to pay on due date.
3. I am liable for all collection costs should I be in default to pay. Such collection costs include party-and-party costs, attorney-and-client costs and trading costs.
4. I undertake to notify this practice of any change of address and/change in Medical Aid Information.
5. This practice has no obligation to send accounts directly to the medical aid and will not be held responsible to do so. It is the patient's responsibility to make sure that the account has been received and dealt with in the appropriate way.

SIGNATURE: PRINT NAME:

Ek kom hiermee ooreen dat;

1. Ek persoonlik aanspreeklik is om die rekeningstaat vir dienste gelewer en/of goedere gekoop te betaal, nieteenstaande die feit dat hierdie praktyk onder bepaalde omstandighede die gelde verskuldig direk van 'n Mediese fonds mag eis.
2. Sou ek versuim om betalings op betaaldatum te doen ek persoonlik aanspreeklik sou wees vir rente op agterstallige betalings.
3. Sou ek versuim om betalings te doen ek persoonlik verantwoordelik sou wees vir alle invorderingskostes. Hierdie kostes sluit in party-en-party kostes, prokureur-en-kliëntkostes en opsporingskostes.
4. Ek hierdie praktyk in kennis te stel van enige wysiging in adresbesonderhede en/of wysiging in Mediese Fonds besonderhede.
5. Hierdie praktyk het nie 'n kontrak of verpligting teenoor enige mediese fonds en aanvaar ook nie die verantwoordelikheid om die rekening na te gaan en te sorg dat dit die mediese fond bereik in sekere gevalle waar dit nodig is nie.

HANDTEKENING: NAAM IN DRUKSKRIF:

REQUIRED BY
SOUTH AFRICAN GOVERNMENT

Dr. Ignatius Botha

Practice #: 4205618
⊠15401, PANORAMA, 7506
Cape Town, South Africa

☎ +27 (0)21 930 3014
✆ +27 (0)21 930 5852
⊡ dribotha@mweb.co.za

Ref: IB/ms/L281/07

AGREEMENT ENTERED INTO BETWEEN DOCTOR & PERSON RESPONSIBLE FOR ACCOUNT

Parties:

Mr/Mrs/Ms *(please give full name)* ______________________________

I.D. #: ______________________ *(hereinafter referred to as "the responsible person")*

of (full physical addresses)

Residence: ______________________________

Business: ______________________________

Tel #: ______________ Fax #: ______________ e-mail: ______________

and

Dr. IGNATIUS BOTHA

MP #: 0206440 ঌ Practice #: 4205618

210 Panorama Medi-Clinic, Rothschild Boulevard, PANORAMA

Agreement:

The responsible person hereby agrees as follows:

1. That (s)he is liable for medical services rendered by the doctor to patient ______________ and, to the extent that it is applicable, s(he) is the parent/legal guardian of the person to whom the medical services were rendered;
2. To pay promptly the account of the doctor in accordance with the tariff of charges prevailing in the doctor's Practice, or as agreed upon between the parties, and in the manner in which the parties have agreed;
3. To settle the doctor's account timely and in full, as agreed, irrespective of contracts/ agreements/arrangements (s)he may have with any medical scheme or any third party.
4. Should the account not be settled in full within 30 business days after the medical services were rendered by the doctor, interest will thereafter be charged on any outstanding amount at a rate of 2% per month until the date that the account is settled in full.
5. Should the doctor institute legal action against the responsible person or hand the account over to a debt collector agent for recovery of any outstanding debts, to pay all costs, including attorney and own client costs, collection fees and tracing fees;
6. It is acknowledged that, in accordance with the provisions of Section 53(1) of the Health Professions Act of 1974 (duly amended) and Section 6(c) of the National Health Act 61 of 2003, the costs associated with all medical services rendered by the doctor, treatment and/or procedures have been discussed and were fully explained to the responsible person and/or patient, to the extent required in law and professional ethics;

7. In accordance with legal requirements the doctor is granted permission to disclose any information about the responsible person and/or the patient, including medical information and/or diagnosis or diagnostic codes, to relevant third parties (such as a funders, administrators, switching companies, prescriptions to pharmacies, and the like) for purposes of processing payment of accounts in respect of medicines dispensed and/or medical services rendered to the responsible person/the patient; as required by a situation. The responsible person and/or patient have been informed that, in certain circumstances, such as disclosure of ICD-10 codes, the exact consequences of disclosing such information is unknown to the doctor and that information relating to these consequences must be obtained by responsible person and/or patient from the third party to whom the information is disclosed.

8. The responsible person and/or patient agree that the doctor may:
   - make enquiries to confirm any information provided by the responsible person and/or patient;
   - seek information from any credit bureau when assessing the responsible person and/or patient's application for credit, or at any time during his/her continuing indebtedness to the doctor including tracing or confirming his/her whereabouts;
   - disclose the existence of his/her account to any credit bureau, sharing both positive and negative payment information about such account.

9. The responsible person and/or patient furthermore, agree that the doctor will be entitled to obtain and disclose the above information:
   - if the doctor considers that it is necessary or may be of benefit to the responsible person and/or patient;
   - where the doctors is under a legal obligation to do so;
   - where it is in the doctor's own or the public interest that he/she does so.

10. **Please be advised that this practice will charge fees higher than the Ethical Tariff suggested by the Health Professional Council of South Africa.** **(Responsible Person: ______________________)** X

11. **The Consultation fee of this Practice is: R900** **(Responsible Person: ______________________)** X

12. **The responsible person and/or patient furthermore should contact this Practice immediately should no account be received 30 (Thirty) days after consultation and/or procedures.**

13. **DISCOVERY MEDICAL AID: DISCOVERY HEALTH MEDICAL AID PAYS DIRECTLY TO THE MAIN MEMBER. ONCE ELECTRONIC PAYMENT IS CONFIRMED BY DISCOVERY TO YOU, YOU HAVE FOURTEEN (14) CALENDAR DAYS TO SETTLE THE ACCOUNT WITH DR I BOTHA IN FULL. IF NOT, LEGAL ACTION WILL BE TAKEN.**

14. The responsible person and/ or patient gives Dr I Botha permission to make use of their hospital medical records to obtain information.

15. **The co-payments for endoscopy for the hospital is linked to your medical plan and separate from doctor's account and is your responsibility. (No motivations will be written for this purpose)**

Signatures:

SIGNED and DATED at **Panorama Medi-Clinic** on this ______________ day of ________________ 2018

Doctor: *(name in print)* Dr. Ignatius Botha (As above) **Signature**: ______________________

Responsible person: *(name in print)* ______________________ **Signature**: X ______________________

Witness: *(name in print)* ______________________ **Signature** ______________________