

Dear Patient,

We would like to welcome you to our practice.

Please note the importance of this document as, once it is signed, it will serve as your full, informed consent to capture, use and store your personal information in referral letters, invoices, quotations and medical certificates. Note that only relevant personal information will be used in documentation to a third party. Additional consent may be required from you if personal information are requested by a third party outside the medical profession.

Our practice can also obtain authorization for the procedure that are suggested, on your behalf. Our accounts department will also submit all claims on your behalf. Our practice uses Solumed software for account processing and Mediswitch for EDI submissions. You will be able to trace payment dates and amounts paid to the practice on your remittance advice from your medical aid.

PLEASE NOTE: ALL outstanding accounts not paid by medical aids stay the liability of the patient at all times, even if authorization has been given by the medical aid. Outstanding accounts will be handed over to our attorneys after 90 days for collection. ALL postal fees and attorney fees, regarding outstanding accounts, will be for your account. After your 3 week check-up appointment, all consultations or alterations will be charged for. Feel free to contact our accounts department during office hours for any queries regarding your account.

STATEMENT AND INFORMED CONSENT

(Please initial on each line)

1. I acknowledge that the capture, storage and use of my personal information by Artificial Eye Aid & Care is necessary to ensure updated contact details and a complete medical record related to my medical history in order for accurate diagnoses to be made with the appropriate treatment and/or corrective measures_____
2. I acknowledge that my relevant information may be used by Artificial Eye Aid & Care in relevant correspondence with a third party which may include my medical aid and/or another medical practitioner_____
3. I understand that in situations where my personal information is passed on to a third party with my consent such information thereafter falls outside the responsibility of Artificial Eye Aid & Care_____
4. I hereby give permission that Artificial Eye Aid & Care may obtain the necessary authorization from my medical aid for the suggested procedures to be done_____
5. I understand and acknowledge that in healthcare the results can not be guaranteed and will also depend on how my body reacts to treatment. I understand that my results will also depend on my own actions and after care regarding my procedure. I give permission for the proposed procedure_____
6. I hereby give permission that my photos may be used in relevant material such as brochures and training material_____

I acknowledge that I am signing these terms and conditions voluntarily without being forced, influenced, pressured or harassed to do so.

Name in print:.....

Signature..... Date.....

Geagte pasiënt,

Baie welkom by ons praktyk.

Let asseblief op die belangrikheid van hierdie dokument. Met ondertekening daarvan dien dit as u volle ingeligte toestemming om u persoonlike inligting te verwerk, te stoor en te gebruik in verwysingsbriewe, rekeningstate, kwotasies en sieknotas. Slegs relevante persoonlike inligting sal gebruik word korrespondensie met 'n derde party. Indien 'n derde party enige verdere inligting verlang, sal ons eers toestemming op skrif van u verkry.

Ons praktyk kan toestemming vir die voorgestelde prosedure, namens u, by u mediese fonds verkry. Ons rekeningafdeling sal ook, namens u, die eis by u mediese fonds indien. Ons gebruik Solumed sagteware vir rekeninge en dien eise in deur Mediswitch EDI submissions. U kan betalings van die rekening nagaan op u betalingstaat wat u van u mediese fonds ontvang.

LET ASB: Alle uitstaande gelde wat nie gedek en betaal word deur u fonds nie, bly u verantwoordelikheid ten alle tye, selfs al het die mediese fonds goedkeuring gegee. Uitstaande rekeninge sal oorhandig word na 90 dae. ALLE kostes (posgeld, regskostes ens.) rakende uitstaande rekeninge, sal u verantwoordelikheid wees. Na afloop van die 3 weke ondersoek sal enige verdere verstellings, konsultasies en/of opbouings betaalbaar wees. U is welkom om ons kantoor te skakel, tydens kantoorure, vir enige verdere navrae rakende u rekening

VERKLARING EN INGELIGTE TOESTEMMING

(Parafeer asb op elke lynnetjie)

1. Ek verstaan en erken dat dit nodig is vir Artificial Eye Aid & Care om my persoonlike inligting vas te lê, te stoor en te gebruik om te verseker dat kontakbesonderhede en 'n volledige mediese rekord ten opsigte van my mediese geskiedenis beskikbaar is vir akkurate diagnose, en geskikte behandeling_____
2. Ek verstaan en erken dat relevante persoonlike inligting, deur Artificial Eye Aid & Care, gebruik kan word in korrespondensie met 'n derde party, bv. my mediese fonds of 'n ander mediese praktisyn_____
3. Ek verstaan dat in situasies waar my persoonlike inligting met my toestemming aan 'n derde party voorsien word, sodanige inligting daarna buite die beheer van Artificial Eye Aid & Care val_____
4. Ek verleen toestemming dat Artificial Eye Aid & Care die nodige goedkeuring van my mediese fonds mag bekom ten einde die voorgestelde prosedures uit te voer_____
5. Ek verstaan en erken dat, in gesondheidsorg, die resultate nie gewaarborg is nie en dat dit afhang van hoe my liggaam op sodanige procedure reageer. Ek verstaan ook dat my resultate ook afhang van my eie aksies en die nasorg wat ek moet doen rakende my procedure. Ek gee toestemming vir die voorgestelde prosedure_____
6. Ek gee hiermee toestemming dat my fotos in relevante materiaal soos brosjures en opleidingsmateriaal gebruik mag word_____

Ek erken dat ek hierdie termes en voorwaardes vrywillig onderteken sonder om beïnvloed, gedwing of afgepers te word.

Naam in drukskrif.....

Handtekening..... Datum.....