Dr. Sampie Smith
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SPECIALIST SURGEON SPESIALIS CHIRURG

Patient Terms and conditions

This is a legally binding agreement between:
Dr Samuel Johannes Smith
And
Name:_____ ID:_____
Please read this agreement carefully and do not sign this agreement unless you fully agree with and understand these terms and conditions:

1. Payment of medical costs, practice billing policy and patient responsibilities

I acknowledge that

1.1. Consultation fee's:
- First consultation: R1000 Non-surgical follow-up consultation: Medical aid tariffs/Private tariff.
- Surgical procedure follow-up: no fee within six weeks of your procedure unless it is for a complication (e.g.: wound infection, fluid collection etc.) or a new problem. Thereafter normal consultation fees apply. Please note that endoscopic procedures such as a gastroscopy and colonoscopy are non-surgical procedures

1.2. If we do not have a contract with your medical aid, your medical aid might not pay us in full for certain procedures. You are responsible to pay this amount, and will be informed about it before you go to theater. Private patients will be billed according to our practice rate, please enquire on a quotation. All after-hours and emergency patients of non-contracted schemes will be billed according to our after-hours and emergency rate. Please feel free to enquire as to how you will be affected by the billing policy.

1.3. If we have a contract with your medical aid you will not be charged a cash fee for a consultation or follow-up unless you're day-to-day is depleted. It remains your responsibility to keep track of your limits in your day-to-day fund.

1.4. Feel free to ask us for a list medical aids that we have a contract with

1.5. It remains the patient's responsibility to read his/her medical aid rules. This is especially important regarding DSP's, referral letters, medical scheme exclusions, authorization numbers for specialist visits and procedures, short-payments and co-payments for procedures and endoscopic procedures

1.6. It is the patient's responsibility to acquire an authorization number for specialist visits and hospital admissions.

1.7. All outstanding accounts must be paid in full within 30 days from date of service. We reserve the right to charge interest and a service fee on accounts older than 30 days

1.8. We make use of sms's, emails, post and phone calls to inform you of outstanding accounts. You undertake to enquire about your account should you not receive one

1.9. You are fully responsible for the payment of services rendered and should you not pay timeously, you understand that you will be liable for debt recovery costs

1.10. It often happens that the medical aid pays the patient and then the patient has to pay Dr. Smith Inc, the patient is then responsible to pay his account at Dr. Smith Inc within 3 days of the money being deposited into his/her account. In failure to do so, a case of fraud can be opened at the local police

1.11. It is your responsibility to phone the practice to book a follow-up consultation after any procedures

1.12. It is your responsibility to phone the practice to enquire about your test results

2. Informed Consent:

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

2.1. The different diagnostic and treatment options generally available to me

2.2. Common and serious side effects of a specific treatment option

2.3. The benefits, risks, costs and consequences associated with each option

2.4. Details of

2.4.1. The diagnosis and prognosis, and the likely prognosis if the condition is left untreated

2.4.2. Any uncertainties regarding the diagnosis

2.4.3. How and when my condition and any side effects will be monitored or re-assessed

2.4.4. That I have the right to seek a second opinion at any time and I may revoke my authorization in writing at any time.

Sign:_____

3. Disclosure of medical information:

I hereby authorise:

3.1. The use and disclosure of my medical information to any relevant doctor as my primary doctor may see fit.
3.2. That a copy of my medical record will be kept by my doctor on file.
3.3. The processing, use and storage of my medical information may be necessary in these circumstances
3.4. The disclosure of relevant medical information to my medical aid, relevant hospital, laboratory and radiology department. This type of information will typically include my diagnosis and my ICD-10 diagnostic code
3.5. The requesting of any medical information such as blood results and radiology reports from the relevant departments.

4. Privacy of medical information (POPI and POIA manuals are available at www.drsampiesmith.co.za)

I acknowledge that

4.1. This practice takes the privacy of its patient very seriously and has implemented reasonable security measures to guard against the unauthorized disclosure of patient information. Firewalls, internet security, locked cupboards, an alarm system as well as a CCTV camera system has been installed to protect personal information.
4.2. My medical information will not be disclosed to unauthorized persons without my consent

I hereby authorise the following person to receive medical information on my behalf (scrap if no applicable)
Name and surname:_____
ID nr:_____ _____
Cell phone nr:_____ Signature of patient

4.3. My patient information may be disclosed by the practice in response to a specific request by a law enforcement agency, subpoena, court order, or as required by law

5. Pre-Authorisation

I am fully aware of the fact that if a procedure requires hospitalisation:

5.1. I am responsible to ensure that my medical aid covers the financial costs of the procedure before I undergo the procedure
5.2. I am responsible to ensure there is authorization for the procedure before the theatre date and take responsibility for any co-payments that my medical aid might apply
5.3. I am aware that this practice charges co-payments for medical aids with which we do not have a contract, you will be informed about your co-payment before your theatre date.

6. I hereby acknowledge and understand that:

6.1. Although I am entitled to ask for a medical certificate from my doctor, he is under no obligation to issue such a certificate
6.2. My diagnosis will be not be disclosed on the medical certificate unless written consent is given.

7. General

I hereby confirm that:

7.1. I have freely chosen this practice to consult with
7.2. I am aware of the fact that the availability of my doctor is generally limited to office hours and consulting times
7.3. I have had an opportunity to review these terms and conditions and that this form accurately reflects my wishes
7.4. I have been made aware of any potential conflicts of interest my doctor may have
7.5. I have read and understood each of the terms and conditions in this agreement
7.6. I am signing these terms and conditions voluntarily without being forced, influenced, pressured or harassed to do so.

8. I hereby understand that:

8.1. My doctor has the right to change his mind about a medical decision at any time
8.2. I am under the obligation to inform the practice of any relevant changes to my personal, medical and/or financial information
8.3. I am under no obligation to sign this form
8.4. I have a right to inspect and/or copy these terms and conditions.

By signing this document you legally bind yourself to the terms and conditions contained herein:

Signature:_____

Date:_____

Sign:_____