Fairview Family Practice

Please complete the following form in its entirety

MAIN MEMBER INFORMATION																			
														ALLERGIES					
SURNAME														TITLE (Mr/Mrs/Dr etc)					
FIRST NAMES																			
DATE OF BIRTH					ID NUMBER														
ADDRESS																			
EMAIL																			
TELEPHONE NUMBERS	HOME				CELL									WORK					

MEDICAL AID DETAILS			
NAME OF SCHEME		OPTION	
MEMBERSHIP NO.		PLAN	
PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT (Should your medical aid NOT pay your account)	NAME		
	TEL NO.		
	ADDRESS		
	EMAIL		

DEPENDANT DETAILS				
NAME AND SURNAME	DATE OF BIRTH	ALLERGIES	CODE	CELL
NEAREST FAMILY/FRIEND		CELL		

1. I CONFIRM THAT THE INFORMATION FURNISHED BY ME ABOVE IS TRUE AND CORRECT.
2. I CONFIRM THAT, PROVIDED MY DOCTOR AND I AGREE ON THE FEES IN ADVANCE, I REMAIN PERSONALLY RESPONSIBLE FOR THE FULL FEE SHOULD THERE BE REJECTION, UNPAID BALANCE. OR ANY SHORT PAYMENT OF MY ACCOUNT BY MY MEDICAL SCHEME.
3. I CONFIRM THAT I WILL PAY INTEREST ON OUTSTANDING AMOUNTS AFTER 30 DAYS FROM DATE OF STATEMENT AT THE CURRENT PRIME LENDING RATE PLUS 2%.
4. I CONFIRM THAT I AM PERSONALLY LIABLE FOR COSTS OF THE SERVICES DELIVERED BY MY DOCTOR TO ME OR MY FAMILY. THE FACT THAT I BELONG TO A MEDICAL AID DOES NOT REMOVE MY ULTIMATE RESPONSIBILITY TO PAY ACCOUNTS FROM THIS PRACTICE.
5. SHOULD LEGAL COST BE INCURRED BY THE PRACTICE AS A RESULT OF MY NON-PAYMENT, I ACKNOWLEDGE THAT THESE ARE FOR MY ACCOUNT AT ATTORNEY CLIENT RATE.

6. POPI COMPLIANCE CLAUSE:
   I HEREBY CONSENT TO THE PROCESSING OF MY PERSONAL INFORMATION CONTEMPLATED IN THE PROTECTION OF PERSONAL INFORMATION ACT NO 4 OF 2013, BY FAIRVIEW FAMILY PRACTITIONERS, THE PRACTICE STAFF AND THIRD PARTIES WITH WHOM FAIRVIEW FAMILY PRACTITIONERS HAS A CONTRACTUAL RELATIONSHIP FOR THE FOLLOWING PURPOSES:

   - TREATING AND MANAGING ME IN TERMS OF A DOCTOR AND PATIENT RELATIONSHIP;
   - THE ADMINISTRATION OF THE CONTRACTUAL RELATIONSHIP BETWEEN MYSELF AND FAIRVIEW FAMILY PRACTITIONERS;
   - COMMUNICATING WITH OTHER PERSONS IN AS MUCH AS IT RELATES TO MY TREATMENT AND MANAGEMENT;
   - COMMUNICATING WITH THIRD PARTIES WHO HAVE UNDERTAKEN TO INDEMNIFY ME FOR THE COSTS OF MY TREATMENT AND MANAGEMENT OR PART THEREOF INCLUDING MEDICAL SCHEMES AND THEIR ADMINISTRATORS WHERE RELEVANT;
     AND
   - COLLECTING MONIES OUTSTANDING FROM ME.

7. MY DOCTOR MAY USE ANY OF THE DETAILS PROVIDED ON THIS FORM TO PURSUE PAYMENT BY ME FOR UNPAID ACCOUNTS FOR WHATEVER REASON. I ALSO AGREE THAT IN THE EVENT OF NON-PAYMENT, MY NAME MAY BE CIRCULATED ON A LIMITED MEDICAL BLACK LIST.
8. I AUTHORISE MY DOCTOR TO DESTROY RECORDS IF THEY HAVE BEEN INACTIVE FOR LONGER THAN 6 YEARS. (Adults) OR IN MINORS, AFTER HAVING REACHED 21 YEARS OF AGE AND THE PATIENT FILE HAVING BEEN DORMANT FOR THE PRECEDING 6 YEARS.
9. I AUTHORISE MY DOCTOR TO PROVIDE MY MEDICAL AID WITH MY PERSONAL MEDICAL INFORMATION FOR THE PURPOSE OF ADMINISTERING CLAIMS.

SIGNED: _____ WITNESSED: _____
(Patient)

NAME: _____

DATE: _____

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