Terms and Conditions:

Acceptance
The undersigned acknowledges that he/she shall be liable for the amount charged by Dr Abelson after the consultation, inclusive of any required material used by Dr Abelson.

Terms of Payment
Every payment by the responsible person arising out of or in connection herewith shall be made at Dr Abelson's practice.

Unless otherwise agreed in writing:

- Payment shall be made not later than 30 days from the date of service.

- Dr Abelson will send the statement to your medical aid, but shall not relieve the responsible person from liability in terms of this agreement.

- Interest at the margin of 2% and a R50 service fee per month will be charged at his discretion on any amount not paid by the responsible person on the due date.

Breach
Should the responsible person fail to make payment on any amount owing to Dr Abelson on due date, the name of the person and of his/her dependants shall be put on a credit control list for the medical profession.

Notices and Domicilia
The parties respectively choose domicilia citandi et executandi for the purposes of all notices and processes arising out of or in connection with this agreement as follows:

- Responsible person: At the street address as indicated on the application form but also contactable at the postal address as on form.

- Any notice sent by either party to the other shall be deemed to be received on the 7th day after the date of posting or on the date of delivery in the case of hand delivery.

- Each party shall be entitled to change the address specified by it in terms of the clause to any other address with no less than 14 days prior written notice given to the other party.

- Should you not have received a statement within 30 days of date of service, please inform our accounts department.

Pre-Authorization
In the event that hospitalization is required for a procedure, it remains your responsibility to ensure that the planned treatment is covered by your medical aid and that the necessary finances are put in place to cover the non-insured costs. If pre-authorization is a pre-requisite for consultations or treatment, it remains your responsibility to furnish the practice with the necessary authorization number. For hospital procedures, Mediclinic Vergelegen runs a Pre-admission Clinic Mondays to Fridays from 09h00 – 15h00 where they will assist you with your admission requirements.

Fraud
Please note that the use of somebody else's medical aid card with or without such a person's consent or knowledge whilst she/he is not a member or dependant of such medical aid amounts to *fraud.* Using funds paid out to you for the doctor's services on anything other than settling his/her bill also amounts to *fraud.* This practice will report such instances to the medical aid concerned as well as the authorities so as to prevent the practice from being held liable as a party to such fraud.

Confidentiality
All information handled by this practice will be regarded and treated as strictly confidential by the doctor and the practice staff. Should you belong to a medical aid and the medical aid forwards such an account to the principal member of the medical aid, confidentially may

not be absolutely preserved, as this practice is required by law to provide certain information to the medical aid on accounts submitted and failure to provide the correct codes might also lead to claims being incorrectly paid.

I understand the implications and agree, where appropriate, to the doctor and practice disclosing my ICD-10 diagnostic code under the conditions described above. ☐

AND

I understand the implications and request that the doctor does not disclose the specifics of my diagnosis. Doctor to use ICD-10 code U98.0 (patient refusing to disclose clinical information). ☐

General
This agreement constitutes the whole and entire agreement between the parties. No variation or modification of this agreement shall be of any force or effect unless the same shall be confirmed in writing and signed by the parties.

Costs
All legal and collection costs, including attorney and client costs, shall be for the account of the responsible person and payable on demand.

________________________ ____________________

Signature Date

DR MARK ABELSON – CARDIOLOGIST **Folder:** (Office use only)..................

PATIENT DETAILS:

Surname: .... **Name: ....**
(names as registered with your medical aid)

ID Number: .... **Date of Birth: ....**

Tel: (home) .... (work) .... (cell) ....

Email: ....

Next of Kin: (name) .... **Relationship: ....**

Tel: (home) .... (work) .... (cell) ....

Referring Doctor: ……………………………………………………………………………………

PERSON RESPONSIBLE FOR ACCOUNT:

Surname: ……………………………………………… **Name:** ……………………………………
(names as registered with your medical aid)

ID Number: ……………………………………………… **Date of Birth:** ……………………………
(please supply us with a copy of your ID book)

Tel: (home) ………………………… **(work)** …………………………… **(cell)** ……………………

Physical address: ……………………………………………………………… **Code:** ………………

Postal address: ………………………………………………………………… **Code:** ………………

Name & address of employer: ……………………………………………………………………

Email address: ……………………………………………………………………………………

MEDICAL AID/INSURANCE DETAILS:

Name of Medical Aid/Insurance: …………………………………………………………………

Name of your specific option: …………………………………………………………………

Membership number: ……………………………………………………………………………

Main Mem Dep No: …………………………… **Patient Dep No:** ………………………………