DR RJ ROUTIER MBBCh (Rand) FCP (SA)
PRACTICE NUMBER 2100304

KINDLY COMPLETE THIS FORM IN FULL WITH CAPITAL LETTERS

DATE	FILE REF	ACCOUNT

TITLE	NAME	SURNAME

DATE OF BIRTH			AGE
IDENTITY NUMBER			
MARITAL STATUS		OCCUPATION	
CELL NUMBER			EMPLOYER AND OCCUPATION
EMAIL ADDRESS			
WORK NUMBER			
CONTACT NUMBER 2			
HOME NUMBER			
PHYSICAL ADDRESS		POSTAL ADDRESS	
MEDICAL AID SCHEME		DEPENDANT CODE	
MEDICAL AID NUMBER			
MEDICAL AID PLAN			
MED AID AUTHORIZATION			
REFERRING DOCTOR			

THE INFORMATION CONTAINED IN THIS FORM IS TRUE AND CORRECT : INITIALS________________

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT / LEGAL GUARDIAN IF MINOR	
NAME:	
CONTACT NUMBER:	
EMAIL:	

DETAILS OF A FRIEND OR RELATIVE AND /OR NEXT OF KIN	
NAME:	
CONTACT NUMBER:	
EMAIL:	
RELATIONSHIP:	

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AGREEMENT DETAILS ; TERMS AND CONDITIONS AND GUARANTEE OF PAYMENT | **INITIALS**

This practice contracts to Platinum Health **on provision of an authorization** number.
Discovery Health and Metaloc are on agreed tariff. **We charge Discovery Premium Rates Only**
You agree to electronic transmission of accounts and records to medical aid. YOU are solely liable for all accounts owed.
We are not responsible for checking data that you have provided or availability of savings and funds. **Payment to the practice is due immediately on the completion of the service provided.**
Non SA Residents and Hospital Plan patients must settle the account at the end of each consultation.
A maximum allowable interest will be charged after 30 days on debt collection outstanding amounts, as well as tracing or legal fees,
These will be levied over and above professional fees, for your sole account.
This agreement is in accordance with the requirements of the Consumer Credit Bill of 1 April 2006.
It is not a credit check nor an offer to provide any terms of credit for this service / consultation.
I the undersigned having read and understood the above guarantee for payment and terms and conditions set out herein
I therfore agree that if I fail to pay any amounts due or fail to comply, all amounts become immediately due and payable.
I will be indebted to the practice for shortfall payments not covered by my medical aid or insurance payments not covered by my medical aid insurance provider, for services rendered.
The creditor or his representative may notify any person whom we think should know thereof without incurring liability there from.
The practice may make enquiries to confirm any information provided by me, on my behalf, seek information from any credit bureau or tracing agent and disclose or list my failure to pay or erratic payment with any credit bureau or financial institution.
I will undertake to pay all interest accrued, legal fees, tracing costs, debt collection costs, tariffs and cost of attorneys charges stipulated by the Debt Collections Act 114 of 1998, related to the recovery of fees outstanding on my medical professional account/s for services rendered.
I will keep the practice informed of any changes to the above information and of failure to receive an account for any reason whatsoever.
A statement of my indebtedness, issued, dated and signed by me on behalf of the creditor shall constitute prima facie proof of indebtedness to the practice and the *quantum thereof* and may be used in and proceedings before a court as proof thereof.

SIGNED ON THIS______________ DAY OF ______________________________20_______
AT OLIVEDALE CLINIC, RANDBURG, JOHANNESBURG.

SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT ____

INITIALING ABOVE CONFIRMS AGREEMENT TO ALL TERMS AND THE CONDITIONS