

DR JASON L. CRANE
MB CHB PRET 1997 FC ORTH (SA) 2008
PRACTICE NO. 0280000324183
ORTHOPAEDIC SURGEON

For Office Use / Vir Kantoor Gebruik

Account No/Rekening No _____

Date/Datum _____

PATIENT DETAILS / BESONDERHEDE VAN PASIËNT

Surname / Van _____ Initials/Voorletters _____ Title/Titel _____

First Name / Voornaam _____ Gender/Geslag Male/Man Fem/Vrou

ID No./Nr. _____ Date of Birth/Geboortedatum _____

Physical Address/Fisiese Adres _____

_____ Code/Kode _____ Tel: (____) _____

Postal Address/Posadres _____

_____ Code/Kode _____ Cell/Sel: _____

Occupation / Beroep _____

Employer/Werkgewer _____ Tel: (____) _____

Business Address/Werksadres _____ Code/Kode _____

Next of Kin/Naasbestaande _____ Relationship/Verwantskap _____ Tel: (____) _____

MEDICAL AID DETAILS / MEDIËSE FONDS BESONDERHEDE (please complete all the fields/ voltooi asb alle velde)

Medical Aid Name/Naam van Mediese Fonds _____

Medical Aid Number / Mediese Fondsnommer _____

Medical Aid Plan/Mediese Fonds Plan _____ Dependant No/Afhanklike Nr _____

MEMBER/PERSON RESPONSIBLE FOR PAYMENT / LID/PERSON VERANTWOORDELIK VIR BETALING

Name/Naam _____ Tel: (____) _____ Cell/Sel: _____

ID No./Nr. _____ Date of Birth/Geboortedatum _____

Postal Address/Posadres _____

_____ Code/Kode _____

Occupation / Beroep _____

Employer/Werkgewer _____ Tel: (____) _____

Business Address/Werksadres _____ Code/Kode _____

E – mail address/E – pos adres: _____

REFERRING DOCTOR / VERWYSENDE GENEESHEER

Surname / Van _____ First Name/Voornaam _____

Practice Location / Praktyk Ligging _____

General Practitioner / Algemene Praktisyn (If different than referring Doctor / Indien verskil van verwysende Geneesheer)

Surname / Van _____ First Name / Voornaam _____

PLEASE NOTE / NEEM ASSEBLIEF KENNIS

This practice charges in excess of NHRPL tariffs (Medical Aid Rates). The following is applicable to ALL patients:

Hierdie praktyk hef slegs NHRPL tariewe (Mediese Fonds) Die volgende is van toepassing vir ALLE pasiente:

SEE REVERSE FOR CONDITIONS OF SERVICE / SIEN KEERSY VIR VOORWAARDES VIR DIENSLEWERING

THIS PRACTICE IS ADMINISTERED BY PRACTICE RELIEF (PTY) LTD.

Ek die ondergetekende, die pasiënt, wettige voog of waarborggewer van die pasiënt op die keersy hierby:

I, the undersigned, the patient, legal guardian guarantor of the patient referred to overleaf hereby:

1. onderneem as hoofskuldenaar, alternatiewelik bind ek myself gesamentlik en/of afsonderlik met die pasiënt, vir die betaling van enige eis van die Praktyk wat mag voortvloei uit medikasie en/of dienste gelewer of gelewer staan te word aan sodanige pasiënt, niesteenstaande die bestaan van 'n mediese fonds of versekering wat die eis nie mag dek nie;
2. neem kennis dat alle rekeninge teen die lewering daarvan betaalbaar is, en indien die bedrag agterstallig is, sal die bedrag verskuldig rente dra teen die prima oortrekkingskoers soos vasgestel deur die Praktyk se bank van tyd tot tyd;
3. onderneem om, indien die rekening om enige rede onvereffen is en na prokureurs verwys word vir invordering, gesamentlik en afsonderlik aanspreeklik te wees vir die betaling van alle koste op 'n prokureur-en-eie-klieënt skaal, alle invorderingskommissie en alle opsporingskoste. Alle uitstaande bedrae sal in die volgende volgorde ingevorder word: prokureursfooie, invorderingskommissie, opsporingskoste, rente en laastens kapitaal;
4. waarborg, indien van toepassing, hiermee dat:
 - 4.1. ek 'n *bona fide* lid van die genoemde mediese hulpskema is;
 - 4.2. die pasiënt 'n *bona fide* lid/afhanklike is;
 - 4.3. daar voordeelfondse beskikbaar is vir sodanige pasiënt;
 - 4.4. ek nie gesekewestreer en nie onderhewig is aan enige wetlike of kontraktuele vermoënsgebrek nie;
 - 4.5. die informasie, soos uiteengesit op die keersy hierby, korrek is;
5. magtig die Praktyk of agent van die Praktyk om enige rekening verskuldig deur die pasiënt aan die genoemde hulpskema voor te lê vir betaling. Desnieteenstaande die voorafgaande word daar spesifiek bepaal dat dit my uitsluitlike plig is om die rekening tydig by die mediese fonds in te dien. Die Praktyk of sy agent sal geen aanspreeklikheid aanvaar in gevalle waar rekeninge nie tydig by die mediese fonds ingedien is nie;
6. kies *domicilium citandi et executandi* te my fisiese adres soos op die keersy hiervan aangedui;
7. magtig die Praktyk, of sy agente, om informasie aangaande die pasiënt se behandeling en/of medikasie aan die pasiënt se mediese hulpskema, bestuurde gesondheidsorg-organisasie of versekeraar te verskaf en hulle agente en werknemers wat daarmee handel. Indien enige van die voorafgenoemde partye ook die pasiënt se werkgewer is, dan verstaan ek dat die informasie ook beskikbaar gestel mag word aan die pasiënt se werkgewer.
8. erken dat 'n sertifikaat:
 - 8.1. geteken deur enige dokter van die Praktyk sal *prima facie* bewys wees van die pasiënt se verpligting teenoor die Praktyk;
 - 8.2. geteken deur enige bestuurder van die Praktyk se bankiers (wie se aanstelling nie bewys hoef te word nie) *prima facie* bewys sal wees van die rentekoers waarna verwys in 2 hierbo;
9. erken dat ek hierdie voorwaardes vrywillig en sonder enige dwang onderteken het en bevestig dat daar geen waarborge of voorstellings gemaak is deur die Praktyk of enige van sy werknemers aangaande die inhoud hiervan nie;
10. erken dat hierdie voorwaardes van toepassing sal wees op alle medikasie en/of dienste gelewer of wat gelewer staan te word deur die Praktyk aan die pasiënt tot dat skriftelik gekanselleer deur my onder die Praktyk se getekende ontvangserkenning.

1. undertake as principal debtor, alternatively bind myself jointly and/or severally with the patient, to pay any claim of the Practice arising from medication and/or services rendered or to be rendered to the patient, notwithstanding the existence of medical aid or insurance covering the claim;
2. acknowledge that all accounts are payable on the rendering thereof, and that any account in arrears will bear interest at the prime overdraft rate of the Practice's bankers from time to time;
3. undertake, in the event of an account being unsettled for any reason and being referred to attorneys for collection, to be jointly and severally liable for the payment of all costs on an attorney and own client scale, all collection commission and all tracing costs. All outstanding amounts will be recovered in the following order: attorney's fees, collection commission, tracing fees; interest and lastly capital;
4. warrant, if applicable, that:
 - 4.1. I am a *bona fide* member of the stated medical aid scheme;
 - 4.2. the patient is a *bona fide* member/dependant;
 - 4.3. there are preference funds available for such patient;
 - 4.4. I have not been sequestrated and do not suffer from any legal or contractual disability;
 - 4.5. the information recorded overleaf is correct;
5. authorise the Practice or agent of the Practice to present for payment to the said medical aid scheme any account owed to the Practice. Notwithstanding the aforesaid, it is specifically recorded that it remains my duty to ensure that all accounts are received by the medical aid scheme timeously. The Practice nor its agent shall incur any liability in instances where accounts are not submitted to the medical aid scheme timeously;
6. choose *domicilium citandi et executandi* at my physical address overleaf;
7. authorise the Practice, or it's agents, to provide information concerning the patient's treatment and/or medication to the patient's medical aid scheme, managed health care organisation or insurer and their respective agents and employees dealing therewith. Should any of the aforementioned parties also be the patient's employer, then I understand that the information may also be made available to the patient's employer;
8. acknowledge that a certificate:
 - 8.1. signed by any doctor of the Practice shall be *prima facie* proof of the patient's indebtedness to the Practice;
 - 8.2. signed by and manager of the Practice's bankers (whose appointment need not be proved) shall be *prima facie* proof of the interest rate referred to in 2 above;
9. acknowledge that I sign these conditions willingly and without duress and that no warranties or representations have been made by the Practice or any of its employees regarding the content hereof;
10. acknowledge that these conditions shall apply to all medication and services rendered or to be rendered by the Practice to the patient until cancelled by me in writing under the Practice's signed acceptance.

PASIËNT/VOOG/
NAMENS PASIËNT.....

PATIENT/GUARDIAN/
ON BEHALF OF THE PATIENT.....

NAAM IN
DRUKSKRIF.....

PLEASE PRINT
NAME HERE.....

BORG.....

GUARANTOR.....

NAAM IN
DRUKSKRIF.....

PLEASE PRINT
NAME HERE.....

DATUM EN TYD.....

DATE AND TIME.....

ONTVANGSPERSOON.....

RECEPTIONIST.....

Dr Jason Lance Crane

Orthopaedic Surgeon

FC Ortho(SA) MMed Ortho(Stel)

Practice Number 0324183

Room 2012 Cape Town Medi-Clinic 21 Hof Street Oranjezicht 8001

Tel: 021 426 2233 Fax: 021426 6677 Cell: 0844033617 e-mail crane@sai.co.za

CONSENT TO THE FEES BEING CHARGED BY THE PRACTICE

I, the undersigned, do hereby-

- . Acknowledge that I have been informed that this practise does not charge the rates that the Department of Health has unilaterally determined for doctors and which are known as the reference Price list (RPL);
- . Confirm that I am aware that that practice fees are charged at up to 3 times the RPL;
- . Confirm that I am aware that the RPL values for services are available from the Department of Health (Tel No: 012 312 0000) and the Health Professions Council of South Africa (Tel no: 012 312 0000) and the Health Professions Council of South Africa (Tel no: 012 338 9300) and www.doh.gov.za;
- . Accept that I am fully responsible for payment for services rendered and should I not pay timeously, understand that I will be liable for Debt recovery costs an attorney and own client scale.

Name:.....

Signature:.....

Date:.....