DR R.H. VAN DER PLANK

M.B.B.Ch. (Wits) F.C.S. (SA) Ortho

Account Number

PATIENT DETAILS

Surname_____ Initials_____ Title: Mr/Mrs/Ms/Prof/Dr/Child_____

First Names_____ ID Number:_____

Date of Birth:_____ Age:_____ Gender: Male | Female

Home (Physical Add)_____ Code_____

Postal Address_____ Code_____

Employer:_____ Occupation:_____

Work Address:_____ Code_____

Work Tel. No:_____ Home Tel. No:_____

Cell Number:_____ Fax No:_____

Referring Doctor:_____ Tel No:_____

Family Doctor:_____ Tel No:_____

PERSON RESPONSIBLE FOR ACCOUNT

PERSON RESPONSIBLE FOR ACCOUNT / ACCOUNT HOLDER / PRINCIPAL MEMBER / LEGAL GUARDIAN

Surname_____ Initials_____ Title: Mr/Mrs/Ms/Prof/Dr/Child_____

First Names_____ ID Number:_____

Date of Birth:_____ Age:_____ Gender: Male | Female

Home (Physical Add)_____ Code_____

Postal Address_____ Code_____

Employer:_____ Occupation:_____

Work Address:_____ Code_____

Work Tel. No:_____ Home Tel. No:_____

Cell Number:_____ Fax No:_____

MEDICAL AID DETAILS

Medical Aid Name:_____ **Member Number**_____

Medical Aid Plan:_____ **Relationship to patient:**_____

E-Mail (Principal member)_____

☞☞☞☞☞ ***Please Turn Over*** ☞☞☞☞☞

NEXT OF KIN DETAILS

NEXT OF KIN/FRIEND OVER 21 YEARS OF AGE WHO IS NOT RESIDING WITH YOU

Surname_____ First Name_____

Work Tel. No:_____Home Tel. No: _____

Cell Number:_____Relationship:_____

I, the undersigned_____
(Full name of PERSON RESPONSIBLE FOR ACCOUNT)

Consent to treatment being performed on the patient as set out above and agree that;

- I am fully responsible for the payment of accounts resulting from the treatment of the patient
- In the event of an account not reaching my postal address or e-mail address as set out above, it is still my responsibility to ensure that payment is made on this account within 60days.
- **I will make sure that I understand the cost involved in my treatment**. Each medical scheme has its own rate and it is my responsibility to ensure that I have made the necessary financial arrangements **BEFORE** accepting treatment either in the rooms or in hospital.
- I acknowledge Dr R.H. Van Der Plank has reserved the right to charge interest at the rate of 24% per annum on accounts older than 60 days.
- I will be liable for all costs including but not limited to legal costs on the High Court scale as between attorney and own client; the costs of collection including all actual collection charges and tracing fees.
- A statement of my indebtedness, issued, dated and signed by the creditor shall constitute prima facie proof of my indebtedness to the creditor and the quantum thereof and may be used in any proceedings before court as proof thereof.
- If I fail to pay any amount that is due or fail to comply with any of the conditions, I expressly agree that;
    - All amounts owing will immediately become due and payable
    - The creditor or its nominated representative may notify any person whom we think should know thereof without incurring any liability therefore; make enquiries to confirm any information provided by me; seek information from any credit bureau or tracing agent; disclose my failure to pay or erratic payment to any credit bureau.
- A statement of my indebtedness, issues, dated and signed by the creditor shall constitute prima facie proof of my indebtedness to the creditor and the quantum thereof and may be used in any proceedings before court as proof thereof.

Signed on this the_____Day of_____20_____(Insert year)

_____
SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT