APPLICATION TO OPEN AN ACCOUNT AND CREDIT AGREEMENT

I the undersigned understand that, in my personal capacity, I stay responsible for the settlement of any costs for the services that I or my dependant will receive. Whether I make provision towards paying my account in any of the following manners: cash, debit or credit card, EFT or membership of a medical aid fund. (Cheques are not accepted.)

VAN DER WALT PHYSIOTHERAPISTS
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PLEASE SELECT WHICH ONE OF THE FOLLOWING ACCOUNT TYPES YOU ARE APPLYING FOR

	ACCOUNT TYPE	METHOD OF PAYMENT	EXPLANATION	COMPLETE SECTIONS
☐	PRIVATE ACCOUNT	SELF PAYMENT	Private account paid on day of consultation. Tariff codes based on the simplified WCA model and not BHF codes. Terms: To be paid at the time of consultation.	A C D
☐	MEDICAL AID ACCOUNT (NOT AVAILABLE TO MEMBERS OF DISCOVERY ADMINISTERED SCHEMES - Refer to separate Discovery letter)	eCLAIMS Electronic submission. Member liable for difference in tariffs	The practice can send the claim electronically to your medical aid as a courtesy. You stay responsible for the account until fully settled, please check with your medical aid regularly to ensure processing of the claim. The practice will not be held liable if the claim is not received by your medical aid. Practice tariff used. You will be required to settle the difference between the practice tariff and your medical aid tariff at the time of consultation. Terms: 60 days	A B C D
☐	MEDICAL AID ACCOUNT	SELF PAYMENT To claim back from funder	Practice tariff used. BHF codes used so that you can claim back your funders' portion from your funder.Terms: To be paid at the time of consultation.	A B C D

THIS PRACTICE IS NOT 'CONTRACTED IN' WITH ANY MEDICAL AID FUNDERS. A PRACTICE TARIFF IS CHARGED, YOU WILL BE REQUIRED TO SETTLE THE DIFFERENCE BETWEEN THE PRACTICE TARIFF AND YOUR FUNDERS' TARIFF

A PERSON RESPONSIBLE FOR ACCOUNT

Title	Full names	Surname
Preferred name	Date of birth DD / MM / YYYY	ID number
Tel Work	Tel Home	Cell

Postal address	Residential address
Occupation	Email address
Employer	Employer address
Clock number / Personel nr	
Marital state	Spouse's name

Spouse's employer	Spouse's work tel nr	Spouse's cell nr

SIGNED AT **WITBANK** ON	DD / MM / YYYY	Signature of person responsible for account#

 # If the person responsible for account is not available to sign, the person completing and signing this form undertakes, without prejudice, full responsibility for settlement of the account if he or she is not the person responsible.

GENERAL TERMS AND CONDITIONS

The responsible person hereby agrees as follows: 1. That *PJ van der Walt t/a van der Walt Physiotherapists* (hereinafter referred to as the Healthcare Provider or **the HCP**) will render an account to the responsible person. If the service is rendered in a hospital, this account will be separate from the hospital's account.

2. That (s)he is liable for medical services rendered by **the HCP** to the patient and, to the extent that it is applicable, (s)he is the patient or parent/legal guardian of the person to whom the medical services were rendered;

3. To pay promptly the account of **the HCP** in accordance with the tariff of charges prevailing at **the HCP**, or as agreed upon between the parties, and in the manner in which the parties have agreed; Furthermore that the tariffs discussed for the purpose of this agreement is affordable to the person responsible at the time of treatment.

4. To settle **the HCP's** account timely and in full, as agreed, irrespective of contracts / agreements / arrangements (s)he may have with any medical scheme, Funder or any third party.

5. Should **the HCP** institute legal action against the responsible person for recovery of any outstanding debts, to pay all legal costs, including attorney and own client fee costs, collection fees and tracing fees;

6. It is acknowledged that, in accordance with the provisions of Section 53(1) of the Health Professions Act of 1974 (duly amended), The Consumer Protection Act 68 of 2008 and Section 6(c) of the National Health Act 61 of 2003, the costs associated with all medical services rendered by **the HCP**, treatment and/or procedures have been discussed and were fully explained to the responsible person and / or patient, to the extent required in law and professional ethics.

7. In accordance with legal requirements **the HCP** is granted permission to disclose any information about the responsible person and/or the patient, including medical information and/or diagnosis or diagnostic codes, to relevant third parties (such as a funders, administrators, switching companies, and the like) for purposes of processing payment of accounts in respect of medical services rendered to the responsible person / the patient; as required by a specific Act or statute, professional ethics or formal policy or directive applicable to the situation. The responsible person and/or patient have been informed that, in certain circumstances, such as disclosure of ICD-10 codes, the exact consequences of disclosing such information is unknown to **the HCP** and that information relating to these consequences must be obtained by the responsible person and/or patient from the third party to whom the information is disclosed. The patient or responsible person hereby agrees that records may be kept in a paper format stored at the practice or in an electronic format, stored on a secure server on site, as well as backup copies stored off site on a secure backup server. All provisions for the safe record keeping of information as specified by the HPCSA as well as the ECT and POPI acts are adhered to.

8. The responsible person and / or patient agree that **the HCP** may: a. make enquiries to confirm any information provided by the responsible person and / or patient; b. seek information from any credit bureau when assessing the responsible person and / or patient's application for credit, or at any time during his/her continuing indebtedness to **the HCP** including tracing or confirming his/her whereabouts; c. disclose the existence of his/her account to any credit bureau, sharing both positive and negative payment information about such account.

9. Supplied contact details, including landline, cellphone, email addresses as well as social media accounts, including Whatsapp, Facebook, Twitter and others, may be used by **the HCP** for the purposes of appropriate communications, including debtor management and appointment scheduling, unless expressly refused by the patient / person responsible, taking the regulations of the ECT Act (25 Of 2002), CPA (68 of 2008) and POPI Act (4 of 2013) into consideration.

10. The responsible person and / or patient furthermore, agree that **the HCP** will be entitled to obtain and disclose the above information:

a. if **the HCP** considers that it is necessary or may be of benefit to the responsible person and / or patient; **b**. where **the HCP** is under a legal obligation to do so; **c**. where it is in **the HCP**'s own or the public interest that he/she does so.

B MEDICAL AID DETAILS

Name of medical aid funder	Benefit option / Plan	Membership number

I confirm that I am aware of the rules and guidelines of my medical aid funder, in regards to physiotherapy benefits. I have ascertained that I do have benefits available and have obtained a pre-authorisation or doctor's referral if my funder requires it. I cannot expect the practice to know the rules of my funder, nor whether I have benefits available. Since I have a contract with the funder, the practice is not allowed to enquire these details from the funder. I understand that should the practice send claims electronically to my funder, that it is a courtesy by the practice and not an obligation. I will follow up with my funder to ascertain that the claims have been processed. I understand that I stay responsible to settle the account regardless of the claims being sent to my funder or not. I agree to settle any amounts not paid for by my funder.

SIGNED AT **WITBANK** ON	DD / MM / YYYY	Signature of person responsible for account / Main member

C RELATIVE NOT LIVING WITH YOU

Title and full names	Surname	Relationship

Address	Tel nr work /home
	Cell

D PATIENT DETAILS

Dependant nr	Title	Full names	Surname

Preferred name	Date of birth DD / MM / YYYY	ID number

Tel Work	Tel Home	Cell

Occupation	Email address

Nature of injury / condition	Referred by and date of referral

Medical history (tick if applicable): I have: [ ] A pacemaker [ ] High blood pressure [ ] Osteoporosis [ ] Metal Implants [ ] Cancer [ ] Communicable diseases [ ] Breast augmentation [ ] I am pregnant / breast feeding [ ] High Cholesterol [ ] Thyroid conditions [ ] Had cortisone treatment in the last 6 weeks

I hereby give consent to treatment. I understand that due to the nature of the treatment I will receive, I might be asked to uncover a specific area or to undress. I further understand that due to the nature of the treatment I will receive, the physiotherapist will be required to physically touch me. I understand that I have the right to refuse both the aforementioned (and that such refusal might have an influence on the outcome of the treatment) or to inform the therapist whenever I do not feel comfortable

SIGNED AT **WITBANK** ON	DD / MM / YYYY	Signature of person receiving treatment (or legal guardian if patient is under 12 years of age)

Dependant nr	Title	Full names	Surname

Preferred name	Date of birth DD / MM / YYYY	ID number

Tel Work	Tel Home	Cell

Occupation	Email address

Nature of injury / condition	Referred by and date of referral

Medical history (tick if applicable): I have: [ ] A pacemaker [ ] High blood pressure [ ] Osteoporosis [ ] Metal Implants [ ] Cancer [ ] Communicable diseases [ ] Breast augmentation [ ] I am pregnant / breast feeding [ ] High Cholesterol [ ] Thyroid problems [ ] Had cortisone treatment in the last 6 weeks

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