Dr. Roshni Naicker
MBBCh(Wits), DCH (SA), FC Paed (SA)
Specialist Paediatrician
PR 0320000005185

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CHILD'S INFORMATION:

Surname:	:______________________	First Name	:______________________
Date of Birth:	:______________________	Gender	:______________________
Dependent Code:	:______________________		

(The 2 digit number on the back of your medical aid card)

Age:	:______________________

DETAILS OF PERSON RESPONSIBLE FOR SETTLEMENT OF ACCOUNT & MEDICAL AID SCHEME DETAILS

Please Note: Consultations are to be settled before leaving the rooms.

Title	: Dr Mr Mrs Ms Miss	Med Aid Name	: ______________________
Surname	:______________________	Med Aid Number	: ______________________
First Name	:______________________	Med Aid Plan	: ______________________
Father ID	:______________________	Tel Number Home	: ______________________
Mother ID	:______________________	Tel Number Work	: ______________________
Postal Address	:______________________	Mom's Cell Number	: ______________________
	______________________	Dad's Cell Number	: ______________________
	______________________	Email Address	: ______________________
Postal Code	:______________________	Alternate Email	: ______________________
Physical Address	:______________________	Referred By Dr	: ______________________
		Employer	: ______________________
		Name Next of Kin	: ______________________
		Or Friend/Relative	: ______________________
		Tel Number	: ______________________

Please read the information over the page and sign in the space provided to indicate that you are fully aware of its contents.

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PLEASE READ CAREFULLY

I, the undersigned, hereby –

1. Acknowledge that I have been informed that this practice **does not charge Medical Aid Rates.**
2. Confirm that this practice requires immediate settlement of all out of hospital consultations, procedures and materials on the day of the consultation, **before leaving the rooms.**
3. Understand my Medical Aid and Plan choice may or may not cover all the fees charged by this practice. (For more information regarding which benefits your chosen medical aid plan includes and/ or excludes, please contact your medical aid scheme)
4. Accept that I am fully responsible for payment for services rendered in hospital and should my medical aid not pay my account within 30 days of the treatment date, I am responsible for settling the account in full and, if necessary, claim from my medical aid in my own capacity.
5. Understand that it is my responsibility to follow up all unpaid in-hospital accounts with my medical aid **and not the responsibility of this practice.**
6. Confirm that I am aware that any **appointment not kept** which has not been cancelled at least 4 hours before the original scheduled time will be charged for at the standard consultation rate.
7. Confirm that I am aware that all **telephonic consultations, written reports and motivations** are charged for.
8. Confirm that I am aware that **any scripts** that are required outside of any consultation (telephonic or otherwise) will be charged for.
9. Confirm that I have read and understand each of the terms and conditions contained in this agreement.

SIGNED :______________________________________

PRINT NAME :______________________________________

DATE :______________________________________