

LONGBEACH MEDICAL CENTRE

Practice No: 0191736

DRS G.CLEVELAND, A. RODRIGUES, B. WITNEY, H. HALL & G. JEMMETT

Please complete only **ONE** form per family:

PERSON RESPONSIBLE FOR THE ACCOUNT

Account number:

Surname:	Initials:	Title:
First name:	ID:	
Postal address:		Postal Code:
Physical address: (if different)		
Employer:		
Work address:		
Home tel no:	Work tel no:	
Cell phone:		
Position in firm:	Spouse tel no:	
Email Address:		

MEDICAL AID DETAILS

Medical Aid	Option
Main Member:	Number:

FAMILY OR FRIEND

Name and Surname:	
Address:	
Relationship:	Tel and code:

FAMILY DETAILS

Name	Nick Name	Date of Birth	Dependant number

I the undersigned do hereby:

- 1) confirm that the above information is true and correct. I undertake to inform you of any changes thereto within 14 days of a change occurring.
- 2) undertake to forward all statements to my Medical aid and to settle all accounts that have not been paid by the medical aid society within 60 days.
- 3) TAKE FULL RESPONSIBILITY FOR THE ACCOUNT.
- 4) accept that as a Private Patient, I am required to settle my account immediately after consult.
- 5) take of the fact that in the event of non-payment by 90 days my name will be added to the "ITC" list of bad payers.
- 6) accept and understand that interest will be charged on accounts older than 30 days.
- 7) accept that in the event of my non-compliance with the above undertaking I will be held liable for payment of all costs incurred in collecting such moneys from me as between attorney and client, including collection commission and tracing costs.

SIGNATURE:	NAME:	DATE:
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8) Popi Compliance Clause : I hereby consent to the processing of my personal information contemplated in The Protection of Personal Information Act of No. 4 of 2013, by the Doctors of Longbeach Medical Centre, The Practice Staff and Third Parties with whom Longbeach Medical Centre has a contractual relationship for the following Purposes :

- Treating and managing me in terms of a Doctor-and-Patient relationship;
- The administration of the contractual relationship between myself and Longbeach Medical Centre;
- Communicating with other persons inasmuch as it relates to my treatment and management;
- Communicating with third parties who have undertaken to indemnify me for the costs of my treatment and management or part thereof including medical schemes and their administrators where relevant;

And

- Collecting monies outstanding from me.
- 9) My Doctor may use any of the details provided on this form to pursue payment by me for unpaid accounts for whatever reason. I also agree that in the event of non-payment, my name may be circulated on a limited medical black list.
- 10) I authorise my Doctor to destroy records if they have been inactive for longer than 6 years, (Adults) or in minors, after having reached 21 years of age and the patient file having been dormant for the preceding 6 years.
- 11) I authorise my Doctor to provide my medical aid with my personal medical information for the purpose of administering claims.

SIGNATURE:	NAME:	DATE:
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