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: