

PATIENT INFORMATION UPDATE	
Patient details	
Surname:	First names:
Date of Birth:	I.D. Number:
Contact Number:	Alternative Contact Number:
Email Address:	
Alternative Email Address:	
Physical Address:	
Person Responsible for Account (if different from patient)	
Surname:	First names:
Date of Birth:	I.D. Number:
Contact Number:	Alternative Contact Number:
Email Address:	
Medical Aid Details	
Name of Medical Aid:	Membership Number:
Main Member's Name:	
Family Details/ Dependants	
Name	Date of Birth
1	
2	
3	
4	
5	

PATIENT ACCOUNT RESPONSIBILITY

By signing this Agreement, I acknowledge and agree that:

I am responsible for ensuring that my contact details remain accurate and up to date, including my physical address, telephone numbers and email address.

I remain responsible for payment of my account in full, including any amount not paid by my medical aid ("medical aid shortfall"). I understand that I am responsible for using the correct payment reference when making payments and for ensuring that such payments are correctly reflected on my account. I undertake to follow up promptly should any payment not reflect on my statement.

Practice accounts are payable within 30 (thirty) days of the date of the statement unless otherwise agreed in writing.

If my account remains unpaid for more than 60 (sixty) days, my account may be classified as overdue, and I understand that the Practice may limit further credit facilities and require payment at the time of consultation.

If my account remains unpaid for 90 (ninety) days and no satisfactory payment arrangement has been made, I acknowledge that the Practice may hand my account over for legal recovery or debt collection. I understand that I may become liable for any additional legal or collection costs permitted by law.

I undertake to notify the Practice immediately should my contact details change and understand that failure to receive statements or reminders due to outdated contact information does not absolve me of responsibility for payment of my account. I agree to receive electronic communication including automated responses on the details provided.

Private patients who do not have medical aid, those who are on hospital plans only, or those whose day-to-day medical aid benefits have been exhausted are required to pay in full on the day that services are rendered.

I have read and understood the Practice's account policy and agree to comply with these terms.

It is the patient's responsibility to ensure that statements are received and to enquire about any outstanding balance if a statement has not been received. Failure to receive a statement does not waive the obligation to pay amounts owing to the Practice.

Patient / Responsible Person Signature: _____

PTO

PATIENT INFORMED CONSENT AGREEMENT for POPI Act 4 of 2013 (POPIA), South Africa
ADDENDUM to PATIENT INFORMATION FORM(S)

AGREEMENT: DR PEISER, VOGTS, COOK, JONCK & DE KRAMER (DR PEISER & ASSOCIATES),
Practice Number: 1408828, hereafter being defined in POPIA as the **Responsible Party**, employ this Agreement to ensure POPIA compliance.

CAPACITY: The person signing this FORM: PATIENT ☐ PARENT ☐ GUARANTOR ☐ GUARDIAN ☐, being defined in POPIA as the **Data Subject** - or, signing on behalf of the **Data Subject** to receive treatment / care:

Patient's name (Data Subject):	ID Number
Person signing this Form:	ID Number

SUBJECT MATTER of this Agreement: Consent for the processing and use of personal information:

Herewith the undersigned, as indicated above (CAPACITY), consents to the processing of personal information by the Responsible Party (including practice staff and authorized third parties with whom the Practice has a service or contractual relationship) and as contemplated in the Protection of Personal Information Act No 4 of 2013 (POPIA), for the following purposes to:

- Identify &/or verify the Data Subject's required details
- Treat & manage care in a doctor-patient-funder-insurance relationship (such as for pre-authorizations)
- Assess products / services of interest to the treatment
- Process data under this Agreement or for legal reasons
- Communicate with other & relevant parties inasmuch it relates to treatment and care management
- Communicate with Third Parties who contract to cover/ indemnify the patient for the costs of treatment or part thereof such as medical schemes/ administrators
- Debt collection agencies / legal services for the purposes of recovering unpaid fees
- Inform patients about Practice products, services & practice messages (such as via email / SMS / other means)
- Process information necessary & in the legitimate interest of the practice, a third party to whom the information is supplied and the patient.

Should any other reason for disclosing information be required, the Practice will first obtain your permission.

Consent by PATIENT/ PARENT/ GUARDIAN/ GUARANTOR

By signing this Agreement, in my CAPACITY to sign, of my own free will without any undue influence from any person whatsoever, I consent to this Agreement.

In the event of me being a dependant, I confirm that I have the explicit permission of my Parent / Guardian / Guarantor - and *vice versa* - to consent & herewith, I indemnify the Practice against this not being the case.

About Withholding Consent

In my CAPACITY as Patient/ Parent/ Guardian/ Guarantor, I understand it is the policy of the practice to require the completion & signing of this consent Agreement.

If you exercise your right to withhold such consent to the practice to collect & process such Personal Information, you understand & agree that in such case, the practice reserves the right not to provide medical services (except emergencies) and for which you in your CAPACITY take full responsibility and herewith indemnify the Practice.

Withdrawal of Consent

In my CAPACITY, I understand that I can withdraw this consent at any time & I undertake to inform the Practice of such withdrawal & in such case, I understand that this may affect my rights & contractual relationship with the Practice for which I take full liability and hereby indemnify the Practice should I opt for such action.

Authorized by PRACTICE

Practice Name: DR PEISER & ASSOCIATES
Practice Number: 1408828

Practice Information Officer: DR RP JONCK

Digitally signed: SIGNATURE

Authorized by PATIENT/ PARENT/ GUARDIAN/ GUARANTOR

Title: _____ First Name:

Surname: _

Contact Number:

Email Address:

Signature: _____

Verified by Practice Administrator:

Name: PRINT NAME

Signature: SIGNATURE