



DR GARY GROENEWALD
Gynaecologist • Obstetrician • Endoscopic Surgeon
MBCHB (Stell), FCOG (SA)

FORM OF ADMISSION													
All fields marked* are mandatory													
*ID Number					*Surname								
*First Names					Initials								
Home Language					Title		DOB:	Y	Y	M	M	D	D
*Cell Number													
*Home number					Marital Status								
*Work Number													
*Email address					Use these contact details for results ☐ Yes ☐ No								
Occupation					Nb: Main members details will be used as alternative								
PERSON RESPONSIBLE FOR ACCOUNT													
*ID Number					*Surname								
*First Names					Initials								
Home Language					Title		DOB:	Y	Y	M	M	D	D
*Cell Number													
*Home number													
*Work Number													
*Email address													
*Postal address									Postal code				
*Physical address									Postal code				
MEDICAL AID DETAILS													
*Medical Scheme					*Plan								
*Membership no.					Gap Cover ☐ Yes ☐ No				Dep code				
GAP Cover Name					Referring Doctor								
NEXT OF KIN- Not from same physical address													
Name				Surname									
Cell number				Title				Relationship					

I the undersigned am aware that this practice charges in excess of NHRPL tariffs/ medical aid rates. I hereby acknowledge that I am fully responsible for payment of services rendered by Dr Groenewald and not my medical aid.

Signed at _____ on this _____ day of _____

Signature: _____



TERMS AND CONDITIONS

1. THE PRACTICE: The Practice means the medical practice as described on the turn side of this Form of admission 2. ACCEPTANCE: The undersigned, patient, responsible person, parent, legal guardian or surety of the patient, hereby assumes liability as the principal debtor, alternatively as co debtor jointly and severally with the patient, for the payment of any claims by the Practice arising from medication given or services rendered to the patient, or to be rendered to the patient, notwithstanding the existence of a medical aid fund or insurance covering such claims. 3. TERMS OF PAYMENT: Any person who signs this document in any of the capacities described above, confirms that (1) he is appraised of the tariffs charged by the Practice (2) he will settle the account within 30 days after receipt (3) he will notify the Practice within 14 days after the treatment date if he has not received an account and (4) the Practice is not liable for the submission of medical claims with any medical fund. 4. BREACH OF CONTRACT: In the event where any of the undersigned parties described in clause 2 above commits a breach of contract, the Practice is immediately entitled to enforce all its contractual remedies. The undersigned specifically agree that any breach of the terms of payment described in clause 3 will constitute a material breach of contract. 5. GENERAL: This Form of Admission constitutes the whole and entire agreement between the parties and there have not been and there are no agreements, representations or warranties between the parties other than those set forth herein. No variation, modification or cancellation of this agreement shall be of any legal force or effect unless the same shall be confirmed in writing and signed by all parties involved. 6. JURISDICTION: This agreement is subject to and shall be interpreted and construed in terms of the laws of the Republic of South Africa and is subject to the jurisdiction of a competent court in the Republic of South Africa. The parties agree that this agreement does not fall within the jurisdiction of the National Credit Act of 2005. 7. PRIVACY POLICY AND PROTECTION OF PERSONAL INFORMATION (POPIA) NOTICE: The Protection of Personal Information (POPI) Act requires us to inform our patients on how we use , disclose and destroy personal information we obtain. We are committed to protecting our patient's privacy and will ensure that your personal information is used appropriately , transparently, securely and according to the applicable legislation. By visiting, interacting with and receiving medical treatment with Dr Groenewald (the practitioner), the patient consents to the following: • My personal information may be collected, processed, recorded, used and must be safeguarded during the rendering of medical services to me by Dr Groenewald hereafter referred to as the practitioner. • The practitioner may also add to my personal information, with information received from other medical service providers and third parties to offer a more comprehensive and appropriate service to me.	• The practitioner may verify, share and disclose my personal information to third parties whose services or implants are used to appropriately render medical services to me. This may include, where applicable: the hospital, anaesthesiologist, general practitioners, surgical assistants and paramedical services involved in my treatment and the booking and planning of surgical interventions. • I have the right to access my personal information which the practitioner holds once my account is paid up to date and that it can take up to 30 days to process my request. • I acknowledge that any information supplied to the practitioner is completely voluntary. • I have the right to request that the practitioner update, correct or delete my personal information on reasonable grounds. This request is to be made in writing by me. • My personal information as well as diagnosis will be disclosed to my medical aid scheme, the practitioners billing company and the main member of the account and/or if applicable my broker. • Medical aid Schemes: Should I not agree for to the disclosure of my diagnosis on my account the medical aid scheme has the right to reject my claim and I will be responsible for settlement of the account. I will provide written notice upon each visit should I not wish for my ICD 10 diagnosis code to appear on my account. • Where applicable; that my personal information as well as diagnosis will be disclosed to the person/entity responsible for the payment of my account ie. to my partner or employer. • Once I object to the practitioner processing my personal information, the practitioner may no longer process my personal information, unless it is within reasonable parameters such as to conclude a transaction or any outstanding business. • Once I withdraw my consent for the practitioner to process my personal information, I understand that the practitioner is still obliged under legislation to keep such information for 5 years after termination of the relationship between the practitioner and myself and/or the practitioner may retain my medical records as protection for as long as the practitioner remains in practice. • The practitioner may disclose my information where they have a duty or a right to do so in terms of applicable legislation or where it may be necessary to do so under any other law. • The practitioner may record and store audio and or video footage of consultations or any surgical procedures between the practitioner and patient for quality and note keeping purposes. • That where I did not give written consent for the practitioner to obtain my information, that the practitioner cannot be held responsible for obtaining such information. • Should I refuse to provide my personal information where the practitioner's purpose for such collection is based on a contractual requirement, legal obligation and /or legitimate interest of the practitioner, I understand that it will hinder the practitioner's ability to perform his duties and responsibilities. Where reasonable justification exists, the practitioner may as a consequence reserve his right to refuse admission, diagnosis and treatment. 8. DOMICILIUM Then parties choose the domicilium citandi et executandi at 403Life Kingsbury Hospital Medical suites; Wilderness Road ; Claremont; Cape Town; 7708 9. LEGAL COSTS Should the practice commence legal proceedings, the patient undertakes to pay all legal costs to the recovery of the outstanding monies in respect of professional services rendered, including the attorney fees on an attorney-own-client scale, collection fees and commission, interest and tracing costs.
I have read, understand and agree to the terms and conditions mentioned above. Signed by Parent/Guardian or person responsible for the account. Signature: Date:	