Dr Mark Harrison
MBChB FCS (SA) Ophthalmology
Ophthalmic Surgeon
Practice No. 0147192

PATIENT DETAILS

Dr/Mr/Mrs/Ms Surname: _____First Names: _____

I.D.Number: _____Date of Birth : _____ Age : _____

Postal Address: _____

Residential Address: _____

Occupation: _____ Employer: _____

Telephone Nos : Home _____ Work: _____

Cell _____ E-mail:_____

Referred By: _____ GP: _____

Would you like a report to be sent to your GP/optician? Yes _____ No _____

Person responsible for the account / Main member of Medical Aid

Title: _____ Surname: _____First Names: _____

I.D. Number: _____ Occupation: _____

Postal Address: _____

Residential Address: _____

Telephone Home: _____ Work: _____

Cell: _____ E-mail: _____

Employer (*Name and Address*): _____

Name of relation or friend *(not residing at the same address)*

Name _____Contact Number_____

Medical Aid details

Name of Medical Aid _____ Plan/Option: _____

Number: _____ Dependent Number: _____

Please note that we submit the account to your medical aid. It is your responsibility to make sure your account is paid in full.

P.T.O

Ground Floor, Suite 5, PMB Eye Hospital, 5 Alan Paton Road, Pietermaritzburg
Howick Mediclinic, 107 Main Street
Tel/Fax: 033 342 5433/4 • E-mail: admin1@eyedoctorpmb.co.za
www.eyedoctorpmb.co.za

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Terms and Conditions of the Practice

By signing this form, you acknowledge that you have understood and agreed to the following:

1. You have had an opportunity to ask questions on aspects thereof that you were not certain about. You can ask Practice or the Doctor, if you do not ask, we will assume that you have understood everything and agree with any processes, consents, policies or forms.

2. The patient and/or the person responsible for the account nominates the above addresses as his/her domicilium citandi et executandi and shall be jointly and severally liable for any account, notwithstanding the specific nomination of another person by the patient as the person responsible for the account.

3. Should the patient and/or person responsible for the account fail to make payment, the account will be handed over for collection and the patient/ or person responsible for the account shall be liable for costs on the scale as between attorney and client.

4. If you do not keep your appointment (for any reason whatsoever, apart from emergencies) and you have not let the practice know at least 24 hours before the appointment, we reserve the right to charge a cancellation fee, as we have kept the slot open for you and could not assist another patient.

CONSENT TO DISCLOSURE OF INFORMATION

1. Consent

I, _____ (full names and surname), an adult person (18 years or older) the parent or legal guardian of a child younger than 12 years of age / a child 12 years or older) hereby authorise, freely and voluntarily and with knowledge of the implications of such consent, the Practice to disclose the specific information outlined herein to the persons and to the extent identified herein:

2. What information is to be disclosed and for what reason? To whom can it be disclosed to?

_____

3. For how long is this consent valid?

_____

Patient can give permission and agree that:
• Another person (such as their parent, a spouse, etc.) sit in at the consultation / procedure. Such a person would then hear and/or see information that would otherwise remain confidential between the patient and healthcare practitioner.
• Another person (such as family members) receive updates on how the patient is doing before, during and/or after a procedure, when in hospital / ICU, etc.
• Another person or entity can get a copy of specific health records (e.g. a copy of the patient's file, a medical report, a copy of a sick certificate, etc.), prescription, etc.
• A person who can consent to treatment and care when the patient cannot (e.g. when the patient is unconscious), can receive information about the patient which will enable them to make the decision.
• The employer be informed of specific aspects, e.g. the nature of the patient's illness, how long s/he would be away and why, etc. Patients take sole responsibility for any consequence that may flow from a disclosure to an employer.
• An insurance company, which require the completion of form, and/or the drafting of a report.
• A pharmaceutical or medical device company, to which details of a negative event associated with a product must be shared.
• A medico-legal report, a report constituting a second opinion, a report to an attorney, etc

Signed at Pietermaritzburg _____ Day of _____ 202

Signature: _____

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