Corné Brink

Clinical Psychologist
Kliniese Sielkundige

M-Care Medical Centre, 72 Rissik street
Potchefstroom

082 926 5159
www.CorneBrink.co.za
Sielkundige@CorneBrink.co.za

Rekeninghouer (Hooflid) / *Account Holder (Main Member)*

Van:
Surname: _____

File no.
(office use)

Volle name:
Full names: _____ Titel: *Title:* _____

Woonadres:
Residential address: _____

Sel. nr.:
Cell no: _____ Tel. nr. (w):
Tel no. (w): _____

E-pos:
E-mail: _____

Mediese Fonds:
Medical Aid: _____ Opsie / Plan:
Option / Plan: _____

Lidnr.:
Member no.:

ID nr.:
ID no.:

Pasiëntbesonderhede / *Patient Details*

Van:
Surname: _____ Volle name:
Full names: _____

Noemnaam:
Called name: _____ Verwantskap met hooflid:
Relationship to main member: _____

ID nr.:
ID no.:

Geb. datum:
Date of birth:
D D M M C C Y Y

Sel nr.:
Cell no.: _____

E-pos:
E-mail: _____

Huisdokter:
Family doctor: _____ Tel. nr. (w):
Tel no. (w): _____

Verwysende dokter:
Referring doctor: _____ indien van toepassing (bv. hospitaliserende psigiater)
when applicable (e.g. hospitalising psychiatrist)

Dorp / Area:
Town / Area: _____ Tel. nr. (w):
Tel no. (w): _____

Naasbestaande / *Next of Kin*

(familie of vriende in 'n ander huishouding / *family or friends in a different household)*

Titel, voorletter & van:
Title, initials & surname: _____

Verwantskap:
Relationship: _____ Sel nr.:
Cell no.: _____

Woonadres:
Residential address: _____

… blaai om (vervolg op rugkant) … / … turn page (continues on reverse side) …

Verklaring & Onderneming

- Hiermee verklaar ek dat al die inligting op hierdie vorm, soos deur my verskaf, waar en korrek is.
- Ek wys hiermee die bostaande adres aan as my gekose *domicilium citandi et executandi* vir die doeleindes van betekening en lewering van enige en alle briewe, kennisgewings, rekeninge, Hofprosesstukke, ens.
- Ek onderneem om die praktyk onmiddellik skriftelik in kennis te stel van enige veranderinge in my pos- en woonadres of enige ander kontakbesonderhede.
- Ek aanvaar volle verantwoordelikheid vir die betaling van my volle rekening, selfs indien die mediese fonds dit nie sou vereffen nie, of dit slegs gedeeltelik sou vereffen.
- Ek onderneem om al my rekeninge streng binne 30 dae ten volle te vereffen.
- Ek stem daartoe in dat hierdie praktyk normale mediesefonds-tariewe hef, en rente byvoeg teen die heersende prima koers van Absa bank indien rekeninge agterstallig is. Ek stem ook daartoe in dat enige kontant-afslag (tariewe laer as mediese fonds-tariewe) verval indien my rekening nie binne 30 dae vereffen is nie.
- Ek begryp dat die volle tarief vir enige sessie wat nie 24 uur vooraf gekanselleer word nie, tot my rekening gevoeg sal word.
- Ek begryp en stem in dat die praktyk se rekeninge (insluitend my rekening) professioneel en konfidensieel deur 'n administratiewe persoon of buite-instansie geadministreer word.
- Hiermee stem ek toe dat, indien hierdie rekening agterstallig sou raak en oorhandig word vir invordering, ek alle rente, prokureurskostes op die skaal soos tussen prokureur en terapeut ooreengekom, en enige ander professionele fooie, kliëntkoste, invorderingsfooie/-kommissie van debiteure administrateurs en enige ander direk of indirek verbandhoudende werklike en noodsaaklike fooie of kostes sal betaal.
- Ek magtig hiermee die Praktyk om my persoonlike inligting en mediese rekords vas te lê en te berg vir akkurate diagnose en toepaslike behandeling en ook om die Praktyk in staat te stel om aan die wetlike vereistes vir mediese rekordhouding te voldoen. Ek magtig die Praktyk verder om enige mediese inligting rakende my sorg, insluitend afskrifte van mediese rekords en/of rekeninginligting van my mediese sorg, aan verteenwoordigers van agentskappe of organisasies (versekeraars) vry te stel in verband met die verkryging van betaling van dienste aan my gelewer. Ek sertifiseer dat die inligting wat deur my gegee is in die aansoek om betaling korrek is, en ek magtig die Praktyk om alle nodige eise namens my in te dien. Ek erken dat hierdie magtiging geen vervaldatum het nie.
- Ek, die ondergetekende, stem hiermee ingevolge die Wet 4 van 2013 op die Beskerming van Persoonlike Inligting (POPIA) toe dat die praktyk my persoonlike inligting met praktyk se administrasiedienste, Mediese Skemas, ander gesondheidsorgverskaffers en skakelhuis mag deel. Alle inligting word as vertroulik beskou en hanteer. Volgens wetgewing moet diagnostiese inligting op rekeninge verskyn. Versuim om dit te doen sal lei tot 'n weiering van betaling van mediese skemas. Die ICD-10-kodes sal geopenbaar word op verwysingsbriewe, versoeke vir spesiale ondersoeke, ens. Ek, die ondergetekende, stem hiermee in dat my ICD-10-kodes openbaar gemaak kan word soos beskryf in die voorwaardes hierbo.

Declaration & Undertaking

- *Hereby I declare that all the information on this form, as provided by myself, is true and correct*
- *I hereby indicate the abovementioned address as my chosen domicilium citandi et executandi for the purpose of signing and delivery of any and all letters, notices, accounts, Court process pieces, etc.*
- *I undertake to inform the practice immediately in writing of any changes of my mailing or residential address or any other contact details.*
- *I accept full responsibility for the payment of my full account, even if the medical aid does not settle the account, or settle only a portion thereof.*
- *I undertake to settle all my accounts in full within 30 days.*
- *I agree that this practice charges normal medical aid tariffs, and adds interest at the current prime rate of Absa bank if accounts are in arrears. I also agree that any cash discount (tariffs below medical aid tariffs) expires if my account is not settled within 30 days.*
- *I understand that the full tariff for any session that is not cancelled 24 hours in advance will be added to my account.*
- *I understand and agree that this practice's accounts (including my account) are administered professionally and confidentially by an administrative person or an external company.*
- *Hereby I agree that, should my account get into arrears and be handed over for recovery, I will pay all interest, legal attorney costs at the scale as agreed between attorney and therapist, and any other professional fees, client costs recovery fees/commission of debit administrators and any other directly or indirectly related actual or necessary fees or costs.*
- *I hereby authorise the Practice to capture and store my personal information and medical records for accurate diagnosis and appropriate treatment and also to enable the Practice to adhere to the legal requirements for medical recordkeeping. I further authorise the Practice to release any medical information concerning my care, including copies of medical records and/or billing information of my medical care, to representatives of agencies or organisations (insurers) in connection with obtaining payment of services rendered to me. I certify that the information given by me in applying for payment is correct, and I authorise the Practice to submit all necessary claims on my behalf. I acknowledge that this authorisation has no expiration date.*
- *I, the undersigned, hereby consent in terms of the Protection of Personal Information Act 4 of 2013 (POPIA) that the practice may share my personal information with practice's administration services, Medical Schemes, other healthcare providers and switching houses. All information is regarded and treated as confidential. As per legislation diagnostic information must appear on accounts. Failure to do so will result in a refusal of payment from medical schemes. The ICD-10 codes will be disclosed on referral letters, requests for special investigations etc. I, the undersigned, hereby agree that my ICD-10 codes may be disclosed as described in the conditions above.*

Geteken op hierdie _____ dag van _____ 202____ te Potchefstroom
Signed on this *day of* *at Potchefstroom*

Handtekening:
Signature: _____

Corné Brink
B.Mus (ed.) Hons. B.A (Psych.) M.A (Psych.)
Practice no: 086 000 0171719
HPCSA: EC Brink: PS 0084603