Dr A KHAN MBChB FCORL. MP 0629 758 / PR 064 2525 **File no:**

Patient Details & Confidentiality Disclosure Consent Form

PATIENT DETAILS

Title: **Initials:** **Surname:**

Full name: **Patient ID NR:**

MEDICAL AID DETAILS

Medical Aid: **Dependant code:**

Option plan: **Medical Aid NR:**

PERSON RESPONSIBLE FOR ACCOUNT

Title: **Initials:** **Surname:**

Full names:

Postal Address: **Code:**

Home Address: **Code:**

ID NR: **Date of Birth:**

Employer:

Home Tel: **Work Tel:** **Cell:**

E-Mail: **Spouse's Cell:** **Spouse's Work Tel:**

NEXT OF KIN (not at the same address)

Title: **Initials:** **Surname:**

Full names:

Relationship: **Tel:**

REFFERING DR NAME:

CONFIDENTIALITY DISCLOSURE AND PAYMENT AGREEMENT

I, the undersigned, as patient, spouse or legal guardian, hereby authorise Dr. A Khan and his accounts department who is in possession of information concerning my medical diagnosis and treatment, together with my health and personal particulars to disclose such information to my Healthcare Funder and other Healthcare Providers.

I further wish to indicate that such permission to disclose such information is only for the purpose of treatment and management of my medical condition.

I, the understanding, hereby agree to the following:

Agree to pay accounts received within 30 days should my medical aid default or should I be a private patient. I undertake to be liable for all legal costs as between attorney and client as well as tracing, collection and administration fees received by the above patient. The practice reserves the right to charge for appointments not cancelled within 24hrs. I testify that all the information is correct and understrand that this statement constitutes a binding agreement.

Full name:

Date:

Signature:

Service date:	Patient:	Comment:	ICD10	Procedure Codes