Dr Gadi Epstein / Prof Nando Ferreira
Limb Reconstruction Surgeon/s

PATIENT INFORMATION					
Title		**Full Names**			
Surname		**Initials**	**Gender**	Male	Female
ID number			**Home Language**		
Cell Number			**Home Number**		
Email address					
Employer			**Work Number**		
Home Address			**Postal Address**		
Post Code			**Post Code**		
Relationship to Main Member					

MAIN MEMBER INFORMATION					
Title		**Full Names**			
Surname		**Initials**	**Gender**	Male	Female
ID number			**Home Language**		
Cell Number			**Home Number**		
Email address					
Employer			**Work Number**		
Home Address			**Postal Address**		
Post Code			**Post Code**		

MEDICAL AID					
Medical Scheme			**Plan/Option**		
Medical Scheme Number			**Gap Cover**	Yes	No

GP DETAILS and/or REFERRING DOCTOR *N.B. This section is VERY IMPORTANT - Please provide details*			
GP		**GP Telephone**	
GP Email			
Referring Doctor		**Telephone**	
Email			

Unit 7 Durbanville Medi Suite
9 Paul Kruger Street, Durbanville 7550
0714581105
gadiepstein@limbreconstruction.co.za
nferreira@limbreconstruction.co.za

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NEXT OF KIN

Relationship to patient _____

Full Names _____ **Surname** _____

Cell number _____ **Initials** _____ Title

I hereby confirm that the information I have supplied is true and correct and that I am responsible for any false information provided.

I hereby confirm that I (or my parent/guardian) remain liable for the account for services rendered by this practice, even if I am insured by a medical aid or other third party

Name in Print _____

Signature _____ **Date** _____

TERMS AND CONDITIONS

Please read this agreement carefully and sign if you fully agree and understand these terms and conditions.

CONSULTATIONS

I am aware of the following:

- Consultations fees: **R1050.00**. **Consultation fees must be paid on the day of the appointment.**

GENERAL

I hereby confirm that:

- I have freely chosen this practice to consult with.
- I do **not** have the doctors consent to record him / her during consultations or during any medical / surgical procedures without his / her consent.
- I confirm that it is my duty as a patient to ensure that my follow up appointments are scheduled and confirmed. I understand that the doctor/s will take steps to make this process as easy as possible, however the ownness is on me, the patient, to confirm the necessary arrangements with the doctor/s rooms.
- I confirm that if I have missed any scheduled follow up appointments that, I the patient, will make alternative arrangements with the rooms for a suitable new follow up date.
- I confirm that I fully understand that the doctor/s rooms are **not** open after normal working hours and that any communication between myself and the rooms after hours will **not** be answered until ordinary hours resume. This applies to periods when the surgeon/s may be on leave.
- I confirm that I understand that if I, the patient, am experiencing severe pain or severe illness of any kind, relating to, or unrelating to my condition or surgical procedure, that it is recommended and in my best interest to visit the nearest emergency unit immediately.
- I am under the obligation to supply true and accurate personal, medical and/or financial information to this practice and that I am responsible for any false information provided.
- I am under the obligation to inform the practice of changes to my personal, medical and/or financial information.
- I hereby authorise a copy of my medical record to be kept on file by my doctor, the practice to have access to my hospital records, radiology and laboratory results and the use and disclosure of my medical information to any other medical service provider as my primary doctor may see fit.
- The disclosure of relevant medical information to my Medical Aid will typically include diagnosis and ICD-10 codes.
- I hereby understand that my doctor has the right to change his mind about a medical decision at any time, as may be done in my best interests as the patient.
- I have had the opportunity to review these terms and conditions and that this form accurately reflects my wishes

By signing this document, you legally bind yourself to the terms and conditions contained herein.

Signature _____ ***Date***_____

Print Name_____

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