Dr Michael Molyneaux
EAR, NOSE & THROAT (ENT) SURGEON
MB ChB FC ORL (SA) MMed (Stell)
Practice NO: 0637297

Tel: +27 (0) 21 201 8709
Email: entcape@gmail.com

SUITE 114 EAST MEDICAL SUITES
CONSTANTIABERG MEDICLINIC
BURNHAM ROAD PLUMSTEAD 7800

ROOM 303 MEDICAL SUITES
KINGSBURY HOSPITAL
CLAREMONT, 7700

All fields marked with * are mandatory	PATIENT INFORMATION		
*Surname		*Full Names	
*ID Number		Title	
Cell number		Date of birth	Y Y Y Y M M D D
*Home number			
*Work number			
*E- mail address			
*Postal address		*Postal Code	
*Physical address		*Postal Code	
Main member's details (If different to patient)			
*Surname		*First Name	
*ID Number		Title	
Cell number		Date of birth	Y Y Y Y M M D D
*Home number		*Work number:	
*E- mail address			

*Medical Scheme:		*Plan/Option		
*Member No:		Dep code	*Gap cover	Yes / No
NEXT OF KIN				
Full Name and surname:		Relationship to Patient:		
Tel (Home or work)		Cell number:		
Who referred you?				
*Postal address			*Postal Code	
*Physical address			*Postal Code	

Terms and conditions of provision of service (full Terms & conditions on back of page)

Appointments not cancelled within 24 hours will be charged for in full.

Fees charged for services rendered may exceed those provided for by your medical aid and any shortfall is for your account.

All repeat scripts, chronic forms, motivation letters, legal forms etc will be charged for your account.

If any outstanding account is not settled within 30 days, interest will be charged on overdue accounts and any excess fees incurred during collection of outstanding fees (e.g legal, client costs etc.) will be for your (the patient's) account.

Agreement:

I agree to take full responsibility for payment of the account and have been informed of the charges/rates applicable. I accept that I am fully responsible for the payment of services rendered and if the medical aid makes a direct payment (part or full) to myself or the main member, I undertake to pay the FULL balance owed without delay.

I the undersigned, acknowledge that I have read/noted, understand and accept these terms and that I am fully responsible for the payment of services rendered by the doctor should the medical fund not pay in full.

Signed at .....on this .....day of ..... 20....

Signed .....

TERME EN VOORWAARDES

1. **DIE PRAKTYK**:
   Die Praktyk beteken die mediese praktyk soos beskryf op die voorkant van hierdie Toelatingsvorm.

2. **AANVAARDING**:
   Die ondergetekende, pasiënt, verantwoordelike person, ouer, wettige voog, of borg van die pasiënt, aanvaar hiermee aanspreeklikheid as hoofskuldenaar, alternatiewelik as medeskuldenaar gesamentlik en afsonderlik met die pasiënt, vir die betaling van enige eise van die Praktyk wat mag voortvloei uit medikasie of dienste gelewer aan die pasiënt, of gelewer staan te word aan die pasiënt, nieteenstaande die bestaan van 'n mediese bystandsfonds of versekering wat sodanige eise mag dek.

3. **BETALINGSVOORWAARDES**
   Enige persoon wat hierdie Toelatingsvorm in enige van die hoedanighede hierbo onderteken, bevestig (1) dat hy homself van die tariewe vergewis het (2) dat hy onderneem om die rekening binne 30 dae na ontvangs te betaal (3) dat hy die Praktyk binne 14 dae na die behandelingsdatum sal kontak en verwittig indien hy nie 'n rekening ontvang het nie en (4) bevestig dat die Praktyk nie verantwoordelik is vir die -- indiening van eise by enige mediese fonds nie.

4. **KONTRAKBREUK**:
   Indien enige van die ondergetekendes beskryf in klousule 2 hierbo enige terme van hierdie kontrak verbreek, is die Praktyk geregtig om onmiddellik regstappe te neem deur die afdwing van alle beskikbare kontraktuele remedies. Die ondergetekendes bevestig spesifiek dat enige verbreking van die betaalvoorwaardes in klousule 3 hierbo, as 'n wesenlike kontrakbreuk bestempel sal word.

5. **ALGEMEEN**:
   Hierdie Toelatingsvorm stel die algehele ooreenkoms tussen die partye daar en geen ooreenkomste, voorstellings of waarborge wat tussen die partye bestaan, anders as wat spesifiek hierin uiteengesit word nie sal van krag wees nie. Geen wysiging, verandering of kansellasie van hierdie ooreenkoms sal enige regskrag dra tensy dit op skrif geplaas word en deur alle betrokke partye onderteken word nie.

6. **JURISDIKSIE**:
   Hierdie ooreenkoms is onderworpe aan, en sal geïnterpreteer word ooreenkomstig die reg en die wetgewing van die Republiek van Suid-Afrika (RSA) en sal onderworpe wees aan die jurisdiksie van 'n bevoegde hof in die RSA. Die partye bevestig dat hierdie ooreenkoms nie binne die jursidiksie van die Nasionale Kredietwet van 2005 val nie

7. **PERSOONLIKE INLIGTING**:
   Die ondergetekende, pasiënt, verantwoordelike persoon, wettige voog, of borg van die pasiënt, gee hiermee toestemming aan die Praktyk om kredietinligting oor hulle te bekom, te deel en uit te ruil met enige kredietburo of ander instelling met wie hulle finansiële transaksies gehad het of kon gehad het, sowel as, waar van toepassing, enige ander inligting wat versoek word kragtens enige omstandighede soos beoog word in die Wet op Nasionale Krediet, Wet 34 van 2005. Bykomend kry die Praktyk ook toestemming om persoonlike mediese inligting soos ICD10 diagnostiese kodes en kliniese inligting ten opsigte van die pasiënt te openbaar aan sy regsverteenwoordigers of skuldinvorderaars met dien verstande dat sodanige inligting as vertroulik en in goeie trou hanteer word slegs tot die mate wat dit vir invorderingsaksies benodig word.

8. **DOMICILIUM**
   Die partye kies as die *domicilium citandi et executandi* die adres soos aangedui op die keersy van hierdie dokument.

9. **REGSKOSTES**:
   Indien die pasiënt nie die rekening betaal nie en die Praktyk besluit om regstappe teen die pasiënt te neem, onderneem die pasiënt om die regskoste te betaal vir die invordering van die uitstaande skuld ten opsigte van mediese dienste gelewer, insluitende prokureursfooie op 'n prokureur-eie-kliënt-skaal, invorderingsfooie en –kommissie, rente en opsporingskostes.

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 submittance 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 specifically 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. **PERSONAL INFORMATION:**
   The undersigned, patient, responsible person,legal guardian, or surety of the patient, hereby authorises the Practice to collect, share and exchange credit information concerning them with any credit bureau or any other person or corporation with whom they may have had or may have financial dealings, as well as, where applicable, other information requested pursuant to, or in any circumstances contemplated in the National Credit Act, Act 34 of 2005. Furthermore, the Practice is given the right to disclose personal medical information such as ICD10 diagnostic codes and clinical information pertaining to the patient to its legal representatives or debt collectors provided that such information is treated as confidential and in good faith and only insofar as it is necessary for debt collecting purposes.

8. **DOMICILIUM**
   The parties choose *the domicilium citandi et executandi* at the address shown on the overleaf

9. **LEGAL COSTS:**
   Should the Practice commence legal proceedings, the patient undertakes to pay all legal costs relating to the recovery of the outstanding monies in respect of professional services rendered, including attorney fees on an attorney-own-client scale, collection fees and commission, interest and tracing costs.