Dr Caterina
"Rinky" Vamvadelis
MP0527459 PR0268313

Dr Deidré Reed
MP0472743 PR0035718

HELDERBERG
Family Practice

Person Responsible for Account / Main Member Details

Title: _____ Initials: _____ Preferred name: _____

Name and Surname: _____

ID/Passport no: _____Date of Birth: _____/_____/_____

Tel: (C) _____ (H) _____ (W)_____

Email Address: _____

Home Address: _____ Code: _____

Employer: _____ Occupation: _____

☐ **Private Patient / Member Medical Aid**

Medical Aid Scheme: _____Medical Aid No: _____

Plan: _____Option: _____Dependant Code: _____

☐ **Same As Above / Patient Details**

Title: _____Initials: _____ Patient relationship to main member: _____

Name & Surname & (Preferred Name): _____

ID/Passport no: _____Date of Birth: _____/_____/_____

Tel: (C) _____ (H) _____ (W)_____

Email Address: _____

Home Address: _____ Code:_____

Employer: _____ Occupation: _____

Dependants

Dependant Code	Title	Full Names	ID / Date of Birth	Cell Number	Email address

***Please turn over the page**

Next of Kin (Emergency Contact – Not Living With You)

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Name & Surname: _____ Relationship: _____

Contact No: _____ Home No: _____

Email Address: _____

Address: _____Code: _____

Terms and Conditions of Service

1. The agreement for rendering of professional services is between the doctors and yourself/family. Medical aids are not contractually bound to the doctors. It therefore remains your responsibility to follow up on your account and to settle within 30 days from date of service, if not already done so by your medical aid.
2. **All accounts please to be settled immediately, unless being submitted to medical aids for processing.**
3. Should an invoice remain unpaid for a period of 90 days from date of service, the matter will be handed over for collection by a firm of attorneys and the cost of collection will be for your account and will be charged in accordance with the National Credit Act.
4. Please keep the practice informed of any changes to your contact details, and particularly the address where you agree to receive all invoices, documents and other written correspondences (domicilllium citande et executandi).
5. Booked appointments that are **not cancelled within 2 hours** of the appointment may be charged a fee. This fee is not covered by medical aid and will be for your account.
6. Invoices and statements of account containing the ICD-10 diagnosis codes will be provided by this practice. I authorise my doctor to provide my medical aid with my personal medical information for the purposes of administering claims.
7. I authorise my doctor to destroy records if they have been inactive for longer than 6 years (adults) or in minors, after having reached 21 years of age and the patient file been dormant for the preceding 6 years.
8. POPI COMPLIANCE CLAUSE: I hereby consent to the processing of my personal information contemplated in the Protection of Personal Information Act No 4 of 2013, by Dr C Vamvadelis & Dr D Reed, the practice staff and third parties with whom Dr C Vamvadelis & Dr D Reed have a contractual relationship with for the following purposes:
    - Treating and managing me in terms of a doctor and patient relationship
    - The administration of the contractual relationship between myself and Dr C Vamvadelis & Dr D Reed
    - Communicating with other persons in as much as it relates to my treatment and management
    - Communicating with third parties who have undertaken to indemnify me for the costs of my treatment and management or part thereof, including all medical schemes and their administrators where relevant
    - Collecting monies outstanding from me.

Declaration by patient/parent/guardian

I have read and understand the terms and conditions of service as set out in this agreement.

I confirm that the information given overleaf is correct.

Name:_____ Signature: _____

Date: _____ Witnessed: _____