Constantia Netcare Clinic
C/O Ontdekkers Road and
Christiaan de Wet Road
Roodepoort, 1724

Dr. LEONORA DE VILLIERS
SIELKUNDIGE|PSYCHOLOGIST
Pr: 8645345 | Ps: 0066990

+27 (0) 82 497 3765
ljdevilliers@psybase.co.za

1. PATIENT INFORMATION			
SURNAME:	FULL NAMES:	❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Prof. ❑ Mx.
IDENTIFICATION NUMBER:	BIRTH DATE: / /	GENDER:	
HOME LANGUAGE:	RESIDENTIAL ADDRESS:		
E-MAIL ADDRESS:			
PAYMENT METHOD: CASH: ❑ MEDICAL AID : ❑	**IF CLAIM IS TO BE SENT TO THE MEDICAL AID:** MEDICAL AID DEPENDENT CODE: _____ _____		
HOME ☎:	WORK ☎:	MOBILE ☎:	
OCCUPATION:	EMPLOYER NAME:		
EMPLOYER CONTACT DETAILS: *(We will only contact your employer if we are unable to reach you for account purposes. Healthcare information will only be provided to a specific person nominated by you at your employer, with your written consent.)*	☎ _____	✉ _____	
FAMILY / FRIEND CONTACT DETAILS: *(for account purposes should we be unable to contact you)* **NAME:**_____	☎ _____	✉ _____	

I hereby accept that –

E-mail ☐ YES ☐NO and/or ***SMS*** ☐ YES ☐NO and/or ***Whatsapp*** ☐ YES ☐NO

messages may be sent to me in order to confirm appointments and convey general information of the practice and my healthcare.

2. MAIN MEMBER / PERSON RESPONSIBLE FOR ACCOUNT / MEDICAL AID DETAILS
(please note that all adults are responsible for their own accounts, even if they are dependents on someone else's scheme)

SURNAME:	FULL NAMES:	❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Prof. ❑ Mx.
IDENTIFICATION NUMBER:	BIRTH DATE: / /	GENDER:	
HOME LANGUAGE:	E-MAIL ADDRESS:	2ND E-MAIL ADDRESS: (if applicable)	
POSTAL ADDRESS:	RESIDENTIAL ADDRESS: (if different from Postal Address)		
HOME ☎:	WORK ☎:	MOBILE ☎:	

PLEASE TURN OVER

BILLING: accounts2@psybase.co.za | +27 (0) 60 670 4702

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MEDICAL AID:	MEDICAL AID PLAN:	MEDICAL AID #:
CURRENT PMB AUTHORISATION? ☐ YES ☐ NO	**IF YES, PLEASE PROVIDE THE FOLLOWING:** APPROVED ICD-10 / PMB AUTHORISATION NUMBER	**IF NO, DO YOU REQUIRE A PMB REAPPLICATION?** ☐ YES ☐ NO
OCCUPATION:	EMPLOYER NAME:	
EMPLOYER CONTACT DETAILS: *(We will only contact your employer if we are unable to reach you for account purposes. Healthcare information will only be provided to a specific person nominated by you at your employer, with your written consent.)*	☎ _____	✉ _____

TERMS & CONDITIONS OF THE PRACTICE

I, the undersigned, confirm that:

1. The above information is true to the best of my knowledge
2. That I have the consent of a family member/friend and my employer to disclose their contact details
3. Where I, the patient, am not the Main Member, I have the consent of the Main Member to disclose his/her details for account administration
4. That the patient (dependent) or main member is primarily responsible for payments of accounts for services rendered
5. Medical schemes differ regarding benefits for services rendered, and that it is the responsibility of the patient or main member to contact the medical scheme prior to appointment/admission to confirm any specific stipulations
6. **I acknowledge and accept, in the event that the Medical Aid does not provide coverage, that I am personally responsible for settling my account**
7. Appointments must be cancelled within 24 hours and failing to do so will result in the full consultation fee being charged
8. I am aware of my rights under the POPI Act, including my right to refuse to consent to marketing and to refuse disclosures - unless required by a law, and to change or remove information, where possible
9. The accompanying ***"Patient Information Document"*** has been read and that I as the patient am bound to the content thereof and that I have had an opportunity to ask questions on aspects thereof that I was not certain about
10. I acknowledge and agree to raise any concern surrounding treatment directly with Dr de Villiers so that therapeutic goals can be reached and concerns can be addressed
11. I understand that while Dr. Leonora de Villiers will provide services to the best of her professional ability, specific results cannot be guaranteed. If I have any concerns about my therapy, I will first discuss them directly with Dr. de Villiers so that we can work together to address them. I agree that, provided services are delivered competently and in line with professional standards, I will not pursue legal action based solely on an unexpected or unsatisfactory outcome
12. The Account Holder, surety or legal guardian hereby consents to the disclosure and exchange of personal financial information to a credit bureau or financial institution in accordance with the National Credit Act

Information about you cannot be exchanged without your consent. Your signature on this release authorises This Practice to obtain and release personal information regarding your care in accordance with PAIA and POPIA Compliance.
Personal & Special Personal Information is collected, stored & shared by This Practice for the following reasons (for a more comprehensive description of all records held at The Practice as well as policies implemented by The Practice, please contact The Practice Information Officer for a copy of the PAIA Manual as well as the POPIA Compliance Manual.

PURPOSE: For the holistic treatment of you as the patient; For the administration of your patient treatment and the practice; For the performance of duties in terms of any agreement between yourself and the practice; Administrate your accounts and manage any application, agreement, or correspondence that you may have with The Practice; Any other reasonably required purpose relating to The Practice.

*Please note, that this practice is administrated by **PSYBASE PRACTICE MANAGEMENT BUREAU** (operator) and as a result, the following information is disclosed for administrative purposes: Client/patient contact and medical aid details, ICD-10 codes, correspondence and Consultation dates and procedures.*

☐ ***I accept this authorization***

☐ ***I do not accept this authorization*** *in the event you choose to keep all information confidential, please note that the payment for all services rendered will be payable on date of service, as the administration process cannot continue)*

1._____ _____
Patient Name **Signature**

2._____ _____
Person Responsible for Account (Main member/patient) **Signature**

Signed at: _____ _____/_____/**20**_____