triplem radiologists

PRIVATE PATIENTS – Account to be settled immediately
MEDICAL AID PATIENTS –Account will be submitted on your behalf, the member remains responsible for the account.
MEDICAL AID CARD AND ID BOOK – Must be produced for every visit or the patient will be treated as private.

PATIENT INFORMATION:

SURNAME:_____

FULL NAME:_____

TITLE:_____DATE OF BIRTH:_____

ID NO:_____

HOME ADDRESS:_____

_____CODE:_____

POSTAL ADDRESS:_____

_____CODE_____

TELEPHONE (H):_____

TELEPHONE (W):_____

CELL PHONE:_____

E-MAIL ADDRESS:_____

OCCUPATION:_____

EMPLOYER:_____

REFERRING DOCTOR:_____

MEDICAL AID:

NAME OF MEDICAL AID:_____

MEDICAL AID PLAN:_____

MEDICAL AID NO:_____

PREGNANT: YES ☐ NO ☐

NEXT OF KIN:(not residing at any of the abovementioned addresses)

RELATIONSHIP TO PATIENT:_____

SURNAME:_____

FULL NAME:_____

ADDRESS:_____

_____CODE:_____

TELEPHONE(H)_____

TELEPHONE(W):_____

CELLPHONE:_____

SIGNATURE:_____

NAME (in print):_____

MAIN MEMBER OF MEDICAL AID:

RELATIONSHIP TO PATIENT:_____
SURNAME:_____

FULL NAMES:_____

TITLE:_____DATE OF BIRTH:_____

ID NO:_____

HOME ADDRESS:_____

_____CODE:_____

POSTAL ADDRESS:_____

_____CODE:_____

TELEPHONE(H):_____

TELEPHONE(W):_____

CELLPHONE:_____

OCCUPATION:_____

EMPLOYER:_____

WORK ADDRESS:_____

_____CODE_____

LIABILITY FOR PAYMENT

I accept personal liability for all the amounts payable to the practice in respect of and incidental to the treatment of and other services rendered to the patient at the practice, notwithstanding the fact that the patient may be a member or a dependent under medical aid / medical benefit scheme and / or be entitled to Workman's Compensation. The fact that the practice may submit a claim to the scheme, Workman's Compensation Commissioner or an insurer will not in any way relieve me of my liability as aforesaid.

All amounts due to the practice are payable within 30 days of service but the practice reserves the right to require payment in advance of all or part of any amount/amounts which may become payable in respect of the treatment of and other services to be rendered to the patient.

The amounts due to the practice in respect of and incidental to the treatment and other services rendered to the patient shall be calculated on the basis of the fees, rates and charges imposed by the practice as at date of signature hereof.

In the event of any amount owed to the practice not being paid on due date, the practice shall be entitled to immediately handover accounts for collection. All legal and tracing fees will be for your account.

DATE:_____

RELATIONSHIP TO PATIENT:_____