DRS CL & ME LANDMAN INC.

ALGEMENE PRAKTISYNS / GENERAL PRACTITIONERS

WELKOM BY ONS PRAKTYK / WELCOME TO OUR PRACTICE

Leêrnommer/*File number*	Office use	Rekeningnommer *Account number*	Office use **AAA**

INLIGTING VAN HOOFLID OF PERSOON VERANTWOORDELIK VIR REKENING
INFORMATION OF MAIN MEMBER OR PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

Van *Surname*			Volle Naam *Full Name*		
Titel *Title*		Voorletters *Initials*		Noemnaam *Known as*	
ID-nommer / *ID number*			Geboortedatum/*DOB*	Ouderdom/*Age*	Geslag/Sex
			D D M M Y Y		M F
Huwelikstatus *Marital Status*			Huistaal *Home Language*		
Allergieë/*Allergies*					
Posadres *Postal Address*	Kode/*Code*:			Sel / *Cell* [**Mnr/Mr**]	
				Sel / *Cell* [***Me./Mrs/Miss***]	
Huisadres *Residential Address*	Kode/*Code*:			☎ Huis / Home	
E-posadres *Email address*				☎ Werk / Work	
Werkgewer *Employer*			Beroep *Occupation*		

MEDIESE FONDS INLIGTING / *MEDICAL SCHEME DETAILS*

Fondsnaam *Name of Scheme*		Voordele-opsie *Benefit Plan Option*	
Lidmaatskapnommer *Membership number*		Hooflid: Naam & Van *Main Member: Name & Surname*	

AFHANKLIKES (VOLTOOI SOOS OP MEDIESE FONDS KAART)
DEPENDANTS (PLEASE COMPLETE AS PER MEDICAL SCHEME CARD)

Code	Naam en Van *Name and Surname*	Noemnaam *Known as*	Selnommer *Cellular number*	M/F	ID nommer / geboortedatum *ID number or DOB*	Allergieë *Allergies*

NAASBESTAANDE IN GEVAL VAN NOOD / NEXT-OF-KIN IN CASE OF EMERGENCY

Naam en Van *Name and Surname*		Verwantskap *Relationship*	
Selnommer *Cellular number*		Kantoornommer *Office number*	

BLAAI ASSEBLIEF OM / PLEASE TURN OVER

Ek, die ondergetekende, verstaan dat ek in my persoonlike hoedanigheid verantwoordelik bly vir die vereffening van alle kostes aangegaan t.o.v. dienste ontvang deur myself of my afhanklikes, hetsy ek enige van die volgende betaalmetodes sou aanwend: kontant, debiet- of kredietkaart, elektroniese oorplasing of lidmaatskap van 'n mediese fonds.

I, the undersigned understand that, in my personal capacity, the settlement of any costs for the services that I or my dependants will receive, remains my responsibility, whether I make provision towards paying my account by any of the following methods: cash, debit or credit card, EFT or membership of a medical aid fund.

Is u onder skuldhersiening en/of onder 'n huidige administrasiebevel van 'n bevoegde Hof vir die bestuur van u skuld? (merk die toepaslike blokkie) *Are you under debt review and/or under an existing Administration Order issued by a competent Court for the management of your debt? (mark the appropriate block)*	JA YES	NEE NO

Terms and Conditions:

1. To the best of my knowledge the above information is true and correct.
2. I authorize the practice to present for payment to the medical aid scheme any amount owed to the practice in respect of myself or the patient.
3. I understand that it remains my duty to ensure that all accounts are received by the medical aid scheme timeously. The practice will incur no liability in instances where accounts are not submitted to the medical aid scheme timeously.
4. I also authorize Drs CL & ME Landman Inc. to release any information required to process my claims.
5. I have acquainted myself with all the terms and tariffs applicable and have noted that:
   a. The terms and a copy of the tariffs applicable to private patients are available from reception;
   b. The terms and tariffs for patients covered by medical aid schemes vary. I understand that I must communicate directly with my medical aid scheme for the applicable tariffs.
6. I undertake, in the event of an account being unsettled for any reason and being referred to attorneys and/or collection agency for collection, to be jointly and severely liable for the payment of all legal costs on an attorney and own client scale, all collection commission and all tracing costs. All outstanding amounts will be recovered in the following order: attorney fees, collection agency fees, collection commission, tracing fees, interest and lastly capital.
7. I hereby warrant that (if applicable):
   a. The patient is a bona fide member of the medical aid scheme mentioned herein and his/her membership is valid at the date of the signing of this agreement; or
   b. I am a bona fide member of the medical aid scheme mentioned herein and my membership is valid at the date of the signing of this agreement, and the patient is a bona fide dependent in terms of such membership; and
   c. I have not been sequestrated and do not suffer from any legal or contractual disability.
8. I choose as domicilium citandi et executandi the address detailed on the front page of this application form.
9. I confirm that the practice may provide a credit bureau with all information regarding these conditions and any non-compliance with the terms thereof by me. I also confirm that the credit bureau may supply a credit profile and a possible credit rating based on my credit worthiness to the practice.
10. No alteration or deletion of any part of this document will be effective unless the practice has signed and dated each variation or deletion.
11. I consent that my contact details as provided may be used to send me statements of accounts, contact me or send me notifications if and when deemed necessary by the practice.
12. I confirm that:
    a. I affixed my signature hereto willingly and without any duress;
    b. I agree to these conditions; and
    c. No misrepresentation with regards to the content hereof has been made.
13. I acknowledge receipt of the following policies:
    a. Medipark Info Sheet
    b. Copy of the above Terms and Conditions of Drs CL & ME Landman Inc.

Handtekening /Signature

(Persoon verantwoordelik vir rekening/Person responsible for account)

Datum
Date

FOR OFFICE USE ONLY

Volledig/Complete		Handtekening (Ontvangs) Signature (Reception)	
Fondskaart Kopie/Medical Aid Card Copied			
GoodX Switch Validasie/Validation		Datum/Date	