EKURHULENI
SURGIKLIN

Patient Label

Admission Contract

Private and Confidential

Important Notes:

1. ***Kindly email/fax this completed admission contract to Surgiklin reception for processing at least 2 days prior to the admission date.***
2. ***Kindly email the main member & patient ID document as well as the medical aid card to admissions@surgiklin.co.za.***
3. ***Please ensure that you have a valid authorization number from your medical aid.***
4. ***Incomplete information will cause a delayed admission process on the date of admission.***
5. ***For queries or assistance please feel free to contact our receptionist/case manager at 087 098 0660.***

Surgiklin Practice Number	0637459	Treating Doctor Practice Number	
Treating Doctor Name		ICD/CPT codes	
Date of admission		Time of admission	
Ward / Bed		File Number	
Referring Doctor Name		House Doctor Name	
Authorization Number		Co-Payment	R
Reference Number / Name		Notes --- ---	

Admission Form

EKURHULENI SURGIKLIN

Patient Details

Title		First Name		Language	
Surname			Nationality		
Date of Birth	D D M M Y Y Y Y	Religion		Disclose	Yes / No
ID					
Tel no (H)			Cell No.		
Tel no (W)			Email		
Home Address				Code	
Postal Address				Code	
Occupation			Company Name		
Company Address				Code	

Medical Aid Details

Medical Scheme Name			Plan / Option		
Membership No			Dependent code		
Joined Date	D D M M Y Y Y Y	Waiting Period	Yes / No	Co-Payment	R
Member Surname			Initials	Relationship to patient	
Tel no (H)			Cell No.		
Tel no (W)			Email		

Person Responsible for The Account

Title		First Name		Surname	
ID					
Tel no (H)			Cell No.		
Tel no (W)			Email		
Home Address				Code	
Postal Address				Code	
Occupation			Company Name		

Admission Form

Next of Kin

Title		First Name		Surname	
Tel no (H)			Cell No.		
Home Address				Code	
Relationship to patient					

WCA / COIDA

Date of Injury	D D M M Y Y Y Y	Employee no	
WCA Registration No		Manager Name	
Tel no (H)		Cell No.	

The above mentioned patient or Guarantor agrees that the patient is admitted to the Clinic subject to and in terms of the standard terms and conditions. That I have read and fully understand the terms and conditions set forth as in the standard terms and conditions of admission.

Name and Surname:

_____

Signature: _____Date: _____

Standard Terms and Conditions of Admission

EKURHULENI SURGIKLIN

In Order to facilitate the treatment of the patient in accordance with said patient's diagnoses, as well as ensure that all obligations as described more fully herein below are adhered to, the patient by signature hereof agrees to the terms and conditions contain herein.

Terms & Conditions	Description
The Clinic	Means Nisasat (PTY) Ltd t/a Ekurhuleni Surgiklin with registration number 2015/358173/07 herein after referred to as Surgiklin.
The Parties	Means the clinic and patient and/or guarantor
The Patient	Means the person whose signature appears on the face hereof and who is to be admitted to the clinic.
A Minor	Means a person younger than 18 years and is not married.
The Guarantor	Means any person who signs these terms and conditions, independently from the patient, parent(s) or guardian, and who accepts full responsibility for payment of Surgiklin's invoice. The Guarantor remains liable for the full outstanding balance unless settled in full by the patient, parent/guardian, main member, medical aid or any other party
Information	Refers to information as is defined in the Protection of Personal Information Act 4 of 2013
Third Parties	Means other service providers who are not employed by Surgiklin but are involved in the provision of various services to the patient.

Initial

Invoices - The patient / guarantor agrees:	
Payment of Account	1. that he/she shall be liable for the payment of any account rendered by the clinic for any treatment/operation undergone by the patient at the tariff rate applicable as may be quoted/ published by the Government Gazette or agreed with any Medical Aid. 2. that he/she undertakes to pay any amounts due to the clinic on discharge or demand, free of the cost of the transfer of monies. 3. that where the guarantor is someone other than the patient, the patient remains liable for all medical services rendered to him as well as all medical goods received including medication.
Minor Patients	4. that where the patient is a minor that both the parents and/or guardians sign these terms and conditions in both their personal and representative capacities and in so doing accept responsibility for payment of the fee in full.
Address for Notices	5. that he/she chooses as his/her home address as set out on the admission form under “patient details” or “guarantor details” for all purposes, including the serving of any court documents such as summonses or notices. A party may change their chosen address by 30 days written notice to the other party.
Consent to the Magistrates Court	6. I/we the undersigned, hereby consent and submit in terms of section 45 of the Magistrates courts Act to the jurisdiction of the appropriate Magistrates Court in respect of all actions or other proceedings which might be brought against me/us by or on behalf of Surgiklin arising out of my/our failure to pay the fee or other breach of the Surgiklin Contract, irrespective of the value of the claim against me/us.
Recovery of Costs	7. That in the event where you have failed to pay the fee mentioned above, Surgiklin have the right to recover any legal costs to recover the amount due. Attorney fees will be recovered by the attorney directly from you.
Receipt of invoices electronically	8. A copy of the account for services rendered will automatically be forwarded to the patient's medical aid scheme provider. 9. I/we the undersigned hereby confirm that Surgiklin may use the email address as indicated in the patient / guarantor details for communication purposes on accounts and/or invoices. Surgiklin may use my personal information for purposes of collecting and recovering any amounts owed by myself to Surgiklin.

Initial

Standard Terms and Conditions of Admission

The patient / guarantor give consents to:	
Consent to access credit information	1. the clinic to do any credit checks they deem appropriate at any credit bureau at any time.
POPPI Act 4 of 2013	2. to the processing as well as retention of information, including special personal information, for the purpose of ensuring the protection of the interest of the patient as well as ensuring compliance with third parties obligations in terms of this agreement. 3. I provide my express consent to Surgiklin to process my personal information as defined in legislation for purposes of providing service and to share such personal information with "third parties" in order to provide various medical and related services to me.

Initial

Claims	
Valuables / Property	The patient accept and agrees that Surgiklin will not be liable or responsible for any loss of, damage or destruction to, any property, including money and valuables, belonging to the patient, or in possession of the patient, or given to Surgiklin for safekeeping, even if Surgiklin is/was negligent in any way and no matter how the loss, damage or destruction was caused.
Personal Information	The patient hereby indemnifies and holds the clinic, the employees, officers, directors, members, agents or representatives of the clinic, acting or purporting to act as such on behalf of the clinic, harmless against-any claim, action, loss, liability or damage that may occur as a result of information being obtained from the clinic, lawfully or otherwise, whereupon the clinic has implemented reasonable information security protocols to prohibit such a breach from occurring.
Exclusion of liability	The patient agrees that the clinic shall not be responsible for any injury sustained by the patient while in the clinic, howsoever caused, if such person is carried by a non-employee, either by stretcher, wheelchair, or in the arms of a patient or guardian.

Initial

South African Jurisdiction and Law
Surgiklin and the use of the Surgiklin facility and any health services provided by Surgiklin to the patient shall be governed by the construed in accordance with the laws of the Republic of South Africa.

Initial

Disclosure of Medical Information
1. I/we, the undersigned SPECIFICALLY GRANTS Surgiklin, its employees, officers, directors, managers, agents, representatives, doctors and nurses his consent to disclose / make available to the medical aid, medical insurer, its employees, officers, directors, managers, members, agents, representatives, all information to be contained within this medical file and hereby disclose personal information of whatsoever nature contained therein; 2. INDEMNIFIES the clinic, its employees, officers, directors, managers, members, agents, representatives, doctors and nurses against any damages, loss, liability of whatever nature incurred, which may be incurred by the clinic, as a result of obtaining/disclosure of such information;

Initial

Signed at _____ on this _____ day of _____201_____.

Signature Patient	**Signature Parent / Guardian**	**Signature Main Member / Guarantor**

Request for Refund

EKURHULENI SURGIKLIN

Name of Patient _____ Patient No. _____

Verification signature of payer _____ Date _____

Email address for proof of payment _____

CASH AND DEBIT CARD TRANSACTIONS

Account Holder: _____ Account Number: _____

Bank: _____ Bank Code: _____

IBAN of Swift Code (For Foriegn Bank): _____

Foreign Bank ☐ RSA Bank ☐

PLEASE NOTE: REFUND PAYMENT WILL BE REFUNDED TO THE PAYEE OF THE DEPOSIT. CASH OR DEBIT CARD PAYMENTS WILL BE REFUNDED VIA EFT.

CREDIT CARD TRANSACTIONS

I (Receipt holder), _____ ID Number _____

Hereby request Ekurhuleni Surgiklin Day Clinic to refund the credit to:

Account Holder: _____ Credit Card Number: _____

Bank: _____ Expiry Date: _____

CVV Number (last 3 digits on back of Card) _____

PLEASE NOTE: WHEN PAYING BY CREDIT CARD THE REFUND WILL BE MADE ON YOUR CREDIT CARD

NOTICE TO ALL PAYING PATIENTS PERMISSION TO PAY OTHER SERVICE PROVIDERS

Patient Name: _____ (This section must be completed by the receipt holder)

I, (Receipt Holder) _____ ID Number _____

Hereby request Ekurhuleni Surgiklin Day Clinic to refund the following suppliers:

Doctors: _____ Doctors: _____

Xrays: _____ Physiotherapist: _____

Pathologist: _____ Orthopaedic Services: _____

Ekurhuleni Surgiklin Day Clinic _____

Other: _____

Signature: _____ Date: _____

NOTE TO RECEPTIONIST: Please attach a copy of the signed receipt to this document

Client Accident/Injury Report

EKURHULENI SURGIKLIN

Date of Injury: _____ Time of Injury: _____

TYPE OF ACCIDENT	X
DOMESTIC	
WCA / INJURY ON DUTY	
MOTOR VEHICLE ACCIDENT	
MOTORBIKE ACCIDENT	
PEDESTRIAN ACCIDENT	

REGISTRATION NUMBER:

_____

WHERE DID THE ACCIDENT OCCUR? **X**

Home	Work	Residential Institution	School	Trade & Service Area	Industrial & Construction Area

SPECIFY IF OTHER: _____

ACTIVITY AT THE TIME OF ACCIDENT: **X**

Sports Activity	Leisure Activity	Working For Income	Other Types of Work	Resting / Sleeping

SPECIFY IF OTHER: _____

MOTOR VEHICLE ACCIDENT/MOTORBIKE ACCIDENT:

TYPE OF VEHICLE: **X**

Three Wheeled Cycle	Truck	Bicycle	Motorbike	Construction Vehicle

WAS THE INJURED PARTY A: **X**

Driver	Passenger	Pedestrian

OWN VEHICLE:	YES	NO
WAS THERE ANOTHER VEHICLE INVOLVED?	YES	NO
WAS THE INCIDENT REPORTED TO THE POLICE	YES	NO

Police station name: _____ Docket number: _____

Please give a detailed description of how the accident occurred:

_____

_____

_____

Should your injury not involve an accident, please specify the following:

Cause: _____ Date of Onset: _____

Detail of Complaint: _____

_____

_____

_____ _____ _____

Patient Signature Admission Clerk Date

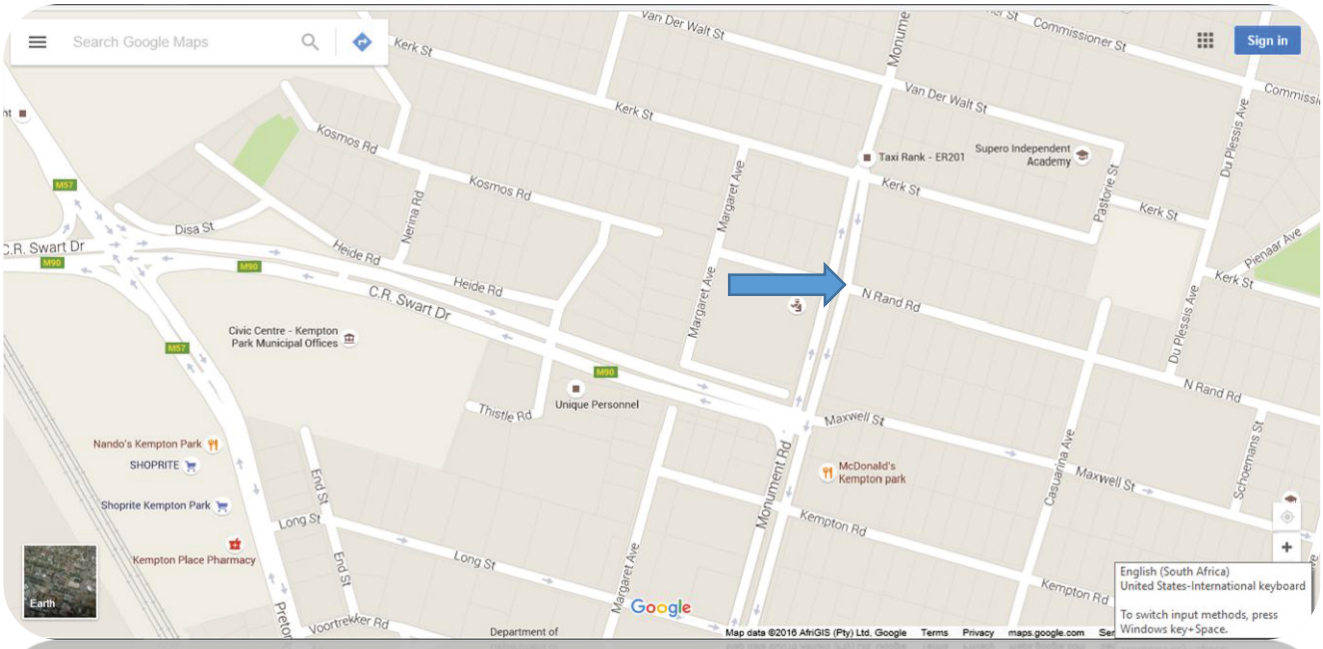
(for office use only)

Admissions Check list:

ID Main Member	
ID Patient	
Doctors Referral Letter	
Medical Aid Card	
Notes: ---------- ----------	

Confirmations:

Authorization Checked	
Co Payment Checked	
Other	
Notes: ---------- ----------	



Ekurhuleni Surgiklin

18 MONUMENT ROAD, KEMPTON PARK

Corner N Rand Rd

087 098 0661

We at Surgiklin wish you/your loved one a speedy recovery!