



PATIENT TERMS AND CONDITIONS

Account number: _____

This is a LEGALLY BINDING AGREEMENT between

Narindi Jansen Optometrists [Practice number: 0177962]

and _____

(Please fill in your name and ID number)

Parent / guardian of _____

(Please fill in the name AND ID number / or date of birth of minor)

Please read this agreement carefully, and sign this agreement once you have read through and UNDERSTAND these terms and conditions. In the event that you are signing this form as the parent or guardian of a minor please read “me” / “my” as “the minor” / “the minor’s” where applicable.

INFORMED CONSENT

I understand that I have the right to ask my optometrist to explain and disclose the following medical information to me before I agree to a medical procedure or treatment:

- The different diagnostic and treatment options generally available to me.
- Common and serious side effects of specific treatment options.
- The benefits, risks, costs and consequences associated with each option.
- Details of the diagnosis and prognosis, and the likely prognosis if the condition is left untreated.
- Any uncertainties regarding the diagnosis or the fact that the treatment is experimental.
- How and when my condition and any side effects will be monitored or re-assessed.
- That I have the right to seek a second opinion at any time.

DISCLOSURE OF MEDICAL INFORMATION

I hereby authorise:

- The use and disclosure of my medical information to any relevant specialist as my optometrist may see fit.
- That a copy of my medical record will be kept by my optometrist on file.
- The processing, use and storage of my medical information as may be necessary in the circumstances.
- The disclosure of relevant medical information to my Medical Aid. This type of information will typically include my diagnosis and my ICD-10 diagnostic code.
- That my medical information will only be disclosed to authorised persons.
- That my patient information may be disclosed by this practice in response to a specific request by a law enforcement agency, subpoena, court order, or as required by law.
- That I am entitled to ask for a medical certificate (or “sick note”) from my optometrist, but he/she is under no obligation to issue such a certificate.
- That my diagnosis will be disclosed on a medical certificate (or “sick note”), should I request one, and that it is my decision whom I show the certificate to.

PAYMENT OF MEDICAL COSTS

I acknowledge that:

- My optometrist will prescribe products that are in my best interests and that said products may not be covered by my chosen Medical Aid or Medical Aid plan.

- My Medical Aid and plan of choice may or may not cover all the fees charged by this practice (*for more information regarding which benefits your chosen medical aid plan includes and / or excludes please contact your Medical Scheme*).
- I am aware that the Rand value for services is available from my Medical Aid according to the option I have chosen.
- I am fully responsible for payment for services rendered and should I not pay timeously, understand that I will be liable for debt recovery costs on an attorney and own client scale.

GENERAL

I understand and confirm that:

- I have freely chosen this practice to consult with.
- I am aware of the fact that the availability of an optometrist at this practice is generally limited to office hours and consulting times.
- My optometrist has the right to change his / her mind about a medical decision at any time.
- I am obliged to inform the practice of any relevant changes to my personal, medical and / or financial information.
- I have had an opportunity to review and understand these terms and conditions.
- I am signing these terms and conditions voluntarily without being forced, influenced, pressured or harassed to do so.
- I have a right to inspect and / or copy these terms and conditions, and my medical file in the practice.

By signing this document you legally bind yourself to the terms and conditions contained herein.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

Please ensure that copies of the following documents are attached to this document

- Copy of the patient's ID document
- Copy of the patient's Medical Scheme Card