Orthodontist / Ortodontis
Practice No. 064 000 0322458

Tel: 014 592 6941 Fax: 014 592 6939
E-mail: johan@johanbaard.com

PATIENT DETAILS: Male ☐ Female ☐ Language preference: English ☐ Afrikaans ☐

Title: Dr/Mr/Mrs/Miss/Ms/Other _____ Surname: _____

Full Names: _____ Date of Birth: _____ Age: _____

Dentist / Referred by: _____ Main complaint: _____

Have you had previous orthodontic treatment? Yes_____ / No_____ Dr: _____

DETAILS OF THE PERSON RESPONSIBLE FOR THE ACCOUNT:

Title: _____ Initials: _____ Surname: _____ First name: _____

ID Number: _____ Marital Status: _____

Postal address: Occupation: _____

_____ Employer: _____

_____ Code: _____ Work Address: _____

Home address: _____ Work Tel: _____ Cell: _____

_____E-mail: _____ Cell spouse: _____

The person responsible for the account chooses *domicilium citandi et executandi* at the abovementioned home address for the purpose of service of all processes and notices, which address may be changed by a 7 day written notice by registered post.

Kindly indicate whether claims should be charged to you or submitted to medical aid → M/A PVT

MEDICAL AID DETAILS:

Scheme: _____ Plan: _____ Membership number: _____

Joining date: _____ Principal member name: _____Dependant no:_____

NB – You are responsible to submit the account to your medical aid as we do not deal with medical aids. We do charge medical aid rates to approved patients but you as patient / parent remains responsible for the account until settled.

RELEVANT MEDICAL HISTORY (Allergies, Heart problems, Rheumatic Fever history, Diabetes, Current medication, etc.)

Tonsils / adenoids still present ☐ removed ☐

Are you currently pregnant or contemplating pregnancy? _____

Next of Kin: (not at same address and telephone number) Relationship: _____

Name & Surname: _____ Occupation: _____ Employer: _____

Address of employer: _____ Tel number: _____Cell: _____

_____ _____ _____

(*)Please print name of person completing this form **Signature** **Date**

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AUTHORISATION / MAGTIGING

I

Ek, _____

(PARENT – FULL NAME) (OUER – VOLLE NAME)

Identity number :

Identiteitsnommer : _____

Herewith give permission for Dr Baard to continue with the treatment of:
Gee hiermee toestemming dat Dr Baard mag voortgaan met die behandeling van:

_____

(PATIENT'S NAME) (PASIËNT SE VOLLE NAAM)

and I take responsibility for any costs not covered by the Medical Aid Fund / Health Care Provider Fund.
en verklaar dat ek verantwoordelikheid neem vir enige kostes wat nie deur die Mediese Fonds betaal word nie.

PHYSICAL ADDRESS - NOT A P.O. BOX *(Domicilium citandi et executandi)*
FISIESE ADRES - NIE 'N POSBUS NIE *(Domicilium citandi et executandi)*

_____

_____

_____

The person responsible for the account chooses *domicilium citandi et executandi* at the abovementioned home address for the purpose of service of all processes and notices, which may be changed by a 7 day written notice by registered post.

Die persoon verantwoordelik vir die rekening kies *domicilium citandi et executandi* vir doeleindes vir die betekening van prosesstukke en kennisgewings, by bogenoemde woonadres, wat verander kan word deur 7 dae kennisgewing by wyse van aangetekende pos.

_____ _____

PARENTS' SIGNATURE / HANDTEKENING VAN OUERS DATE / DATUM

_____

NAME IN PRINT / NAAM IN DRUKSKRIF

RETURN FULLY COMPLETED AND SIGNED TO THE PRACTICE
BESORG TEN VOLLE INGEVUL EN GETEKEN TERUG AAN DIE PRAKTYK
Dr Johan Baard – for attention – accounts / vir aandag – rekeninge

DR JOHAN BAARD
ORTHODONTIST

Orthodontist / Ortodontis
Practice No. 064 000 0322458

Tel: 014 592 6941 Fax: 014 592 6939
E-mail: johan@johanbaard.com

Notice: Financial Policy and your responsibility

To all our esteemed clients

Due to increasing problems experienced with medical aid schemes, we would like to draw your attention to our current financial policy. This policy revokes all previous financial policies.

- The main member of the medical scheme is **liable** for the payment of the account, irrespective of the benefit structure of his/her medical aid scheme.
- Your account is payable within **60 days.** It is your responsibility to ensure that the medical scheme has paid your account on time. We will accept no verbal agreement or promises of payment; we will accept proof of payment.
- **To assist you** in receiving your legitimate benefits from your medical aid, we will continue to submit a copy of your account to your medical scheme every month. This is to help you to speed up the processing of your claims. **However,** it remains your responsibility to make sure that your medical scheme has received your account. **We do not provide proof of delivery of accounts.** It remains your responsibility.
- We will mail an account to you every month so you can check the status of your account. The onus is on you to inform us if you have not received an account. It remains **your responsibility** to check your account and **to ensure that the fund receives your account, and that payment is effected within the prescribed period. Our financial policy is in force as if you received an account.**
- We will continue to provide the necessary reports and quotes to you **to enable you** to ascertain benefits and authority to utilize your available funds. It remains your responsibility to establish beforehand what funds are available for orthodontics, and to calculate your own liabilities.
- All amounts that are not paid within 90 days **are automatically handed over** for debt collection. Kindly take note that this process occurs automatically and that you will not be contacted in this regard. **Warnings do occur on your accounts.**
- In the event that legal action is taken in order to collect overdue payments, you will be held liable for all legal costs. Should it be deemed necessary to hand over your account, you will be liable for the full costs of your account and all monies due to the practice at that point.
- If you do not abide by this prescribed financial policy, I will reserve all rights to stop any **active** treatment in **the event of legal action** in order to collect overdue payments. I will then render **emergency services** on a cash-only basis.

DR JOHAN BAARD

_____ _____

MEMBER / GUARDIAN SIGNATURE **DATE**

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URGENT NOTICE

I, _____, ID nr _____, hereby confirm that the following details have been explained to me and that I fully understand the details thereof:

1. This agreement is between the member and Dr Baard, NOT between Dr Baard and the member`s medical aid;
2. Even though all claims are being submitted to the medical aid by Dr Baard, it remains the responsibility of the member to follow up on payments. Should the medical aid fail to make payments, it remains the responsibility of the member to make these payments;
3. Authorisation received from the medical aid is subject to available funds. Should funds be depleted, it remains the responsibility of the member to make payments until such time that the funds has been renewed;
4. Please take note of the exclusions on your quotation: broken blocks, x-rays, follow up appointments after deband (removing the braces), as well as any laboratory costs. These are NOT included in the treatment amount.
5. Please take note of the costs for deband (removing the braces). This is NOT included in the treatment amount, and is payable **on the day** of the deband, as well as any outstanding amount on the account, together with any outstanding monthly instalments.
6. Should your account be handed over for debt collection, you will be responsible for any legal costs incurred.

BELANGRIKE KENNISGEWING

Ek, _____, ID no_____, bevestig hiermee dat die volgende besonderhede aan my verduidelik is en dat ek dit ten volle verstaan:

1. Hierdie ooreenkoms is tussen die hooflid en Dr Baard, en NIE tussen Dr Baard en die hooflid se mediese fonds nie;
2. Alhoewel alle eise deurgestuur word na die mediese fonds deur Dr Baard, bly dit steeds die hooflid se verantwoordelikheid om betalings op te volg. Indien die fonds nie betalings maak nie, bly dit die hooflid se verantwoordelikheid om hierdie betalings te doen;
3. Magtiging verkry vanaf die mediese fonds, is onderhewig aan beskikbare fondse. Indien fondse uitgeput is, bly dit die hooflid se verantwoordelikheid om betalings te doen totdat fondse hernu word;
4. Neem asb kennis van die uitsluitings op u kwotasie: afgebreekte blokkies, xstrale, opvolg afsprake na debandering (afhaal van draadjies) asook enige laboratorium kostes. Hierdie is NIE ingesluit in die behandelings totaal nie;
5. Neem asb kennis van die koste van debandering (afhaal van draadjies). Hierdie is NIE ingesluit in die behandelings totaal nie, en is betaalbaar op die dag van debandering, asook enige uitstaande bedrag op die rekening, tesame met enige uitstaande maandpaaiemente;
6. Sou u rekening oorhandig word vir invordering, sal u self verantwoordelik wees vir enige regskostes.

Member / Hooflid

_____

Witness / Getuie

_____