Dr Steven G. Smith

Specialist Anaesthesiologist

MBBCh (Wits), FCA(SA)
Practice number: 010 000 0090271

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Patient Details **Invoice Number:** **ANA** _____

Name of Patient: _____
ID No./ Date of Birth: _____
Occupation: _____

Person Responsible for Account

Surname: _____
Full Names: _____
Occupation: _____
ID Number: _____
Postal Address: _____

_____

Residential Address: _____

_____

Relationship to Patient: _____ Tel. (Home): _____
E-mail: _____ Cell: _____
Employer's or Business Name: _____ Tel. (Work): _____
Business Address: _____ Fax: _____

_____

Patient Sticker

Medical Aid Details

Name of Medical Aid: _____ Medical Aid Number: _____
Member Name: _____ GAP COVER/ TOP -UP COVER: YES/ NO

Family Member or Friend Not Living With You

Name: _____ Telephone Number: _____

Consent for Anaesthesia and Agreement between the Anaesthesiologist and the Patient/ Legal Guardian/ Person Responsible for Payment of the Account

Safety

No food or liquid should be taken for 6 hours prior to the administration of anaesthesia.
I agree not to drive a motor vehicle, drink alcohol, sign contracts or make any important decisions for 24 hours after anaesthesia.

Payment

The anaesthetic account is rendered completely independently from the accounts of the surgeon and the hospital.
This practice is contracted out of medical aid (excluding Discovery Health). Payment is to be made directly to Dr Smith and then recovered from your medical aid.
All anaesthetic tariffs charged may not be fully reimbursed by your medical aid.
The patient/guarantor of payment is personally responsible for payment of the account and agrees to pay the anaesthesiologist's fee.
Terms of payment are strictly 30 days from date of invoice. Payment may be made by credit card or by direct deposit.
I undertake to pay all legal, debt collection and tracing costs on the attorney and own client scale as well as all other charges as stipulated by the Debt Collectors Act 114 of 1998 relating to the recovery of fees outstanding on my account in respect of anaesthetic and other professional services rendered.
I confirm that the nominated postal and/or email address are correct for the purpose of receipt of the anaesthetic account.
I hereby choose my above address as my domicilium citandi et executandi for all purposes under this agreement and I agree that any notice sent to my domicilium citandi et executandi by prepaid registered post shall be deemed to have been received by me on the third business day after posting of same.
I agree that any notice actually received by me shall be valid for all legal purposes notwithstanding that it was not sent to me by registered post and/or that was not sent to me at my chosen domicilium citandi et executandi.
I agree that in the event of my wishing to change my domicilium citandi et executandi, I shall be required to give one weeks written notice of such change becoming effective.

I confirm that I/the patient have/has been informed of the nature of the anaesthetic and that the benefits, risks and consequences generally associated with the anaesthetic have been explained to me/the patient, as have the tariffs that will be charged for the anaesthetic, ***as per the tariff information sheet overleaf****.*
I understand that no-one is able to guarantee an incident-free anaesthetic.
I have read, understood, and agree to the conditions mentioned above, as well as in the tariff information overleaf*.*
I confirm that the informationprovided by me on this form is true and complete in all respects.
I hereby give permission for anaesthesia to be administered to my dependant or myself.

Signature: _____ ***Witness:*** _____ ***Place:*** _____ ***Date:*** _____