

DR SG SMITH ANAESTHESIOLOGY INC.

2024/542660/21

DR STEVEN SMITH

MBBCh (WITS), FCA(SA)

PRACTICE NUMBER: 9990100001 199374

EMAIL: PERFECTBILLS@MWEB.CO.ZA

TEL: (011) 672 6466

WWW.DUNKELDANAESTHETICPRACTICE.COM

PATIENT DETAILS

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: _____

E-mail: _____

Employer's or Business Name: _____

Business Address: _____

INVOICE NUMBER:

ANA

Patient Sticker

Tel. (Home): _____

Cell: _____

Tel. (Work): _____

Fax: _____

MEDICAL AID DETAILS

Name of Medical Aid: _____

Medical Aid Number: _____

Member Name: _____

GAP COVER/ TOP -UP COVER: (please circle) YES or NO

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 SG Smith Anaesthesiology Inc. 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 as follows:

Elective Surgery: R6 271 for the 1st hour and then **R2 370** per half hour period thereafter.

Emergency Surgery: R8 513 for the 1st hour and then **R2 994** per half hour period thereafter.

In addition, modifiers with applicable costs may apply as per the tariff information sheet overleaf.

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 information provided 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 for the following procedure:

Procedure: _____

Signature _____ **Date** _____