CLIENT PARTICULARS AND CONTRACT (First name:)

Title:

Full Names & Surname:

ID:

Gender: M F

Marital Status:

Postal Address: ______________________________
____
______________________________ Code: ________

Residential Address: ______________________________
____
____
____
______________________________ Code: ________

Language:

Tel. (H):

Cell:

(W):

E-mail:

Occupation:

Family Doctor:

PERSON RESPONSIBLE FOR ACCOUNT (If Not The Client)

Title:

Full Names & Surname:

ID:

Postal Address: ______________________________
____
______________________________ Code: ________

Tel (H):

Tel (W):

Cell:

Residential Address: ______________________________
____
____
______________________________Code: ________

Medical Aid: YES NO

Medical Aid Name:

Option:

Membership No:

Dependant Code:

Main Member Initials & Surname:

HOW DID YOU COME TO HEAR ABOUT MY PRACTICE?

☐ My website ☐ Referred by a Doctor (Please specify: ______________________________)

☐ Friend ☐ Other (Please specify: ______________________________)

CONTRACT

Accounts are levied according to the recommendation of the BHF (Board of Healthcare Funders).

Claims are submitted electronically to the Medical Scheme. If the client does not belong to a Medical Scheme, or where the Medical Scheme only pays the member, or where the member has to submit the claims, an account will be rendered to the client at the end of the month.

The terms of payment are strictly 30 days from the date reflected on the statement.

Interest will be charged if the account is not settled within 60 days of invoice. Outstanding amounts, together with collection commission and legal fees arising from non-payment will be the responsibility of the client.

It remains the responsibility of the client to:

- Clear out with his /her Medical Scheme in terms of their agreement with Psychologists.
- See that the account gets paid.
- Make sure there are enough funds available.

APPOINTMENTS NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE WILL BE CHARGED FOR

AGREEMENT

1. I hereby confirm that all information supplied by me is true and correct.
2. I accept the above-mentioned terms of payment as well as account liabilities.
3. I understand that all information will be handled confidentially.
4. I have received and read the additional information booklet regarding this practice.
5. Other ____

Signature: ____ Date: ____ / ____ / ____