Dr Rory Dower

Specialist Plastic, Reconstructive & Aesthetic Surgeon

MRCS (Eng) MMed (Plast Surg) FC Plast Surg (SA)
PR 0484547 . MP 0571431

Trading in Dr Rory Dower Inc
2016/261711/21

Busamed Paardevlei Private Hospital
Room 201
4 Gardner Williams Avenue
Paardevlei Estate
Somerset West
7130

Mediclinic Vergelegen
Block 1, Suite 5
Main Road
Cherrywood Gardens
Somerset West
7130

Telephone: 021 840 7108
Email: admin@drdower.com
Website: www.drdower.com

WELCOME TO DR DOWER'S PRACTICE

How did you learn about Dr Dower? _____

PATIENT

First Name: _____

Surname: _____

Preferred name (if different from above): _____

Title: _____ Initials: _____ Gender: M F

ID: _____

Home language: _____

Home Address: _____

_____ Postal code: _____

Home phone: _____

Cell Phone: _____ Use this number for correspondence: Y N

E-mail: _____ Use this for correspondence/statements: Y N

Occupation: _____ Employer: _____

Relationship to Main Member (if applicable): _____

Patient Dep Code: _____

Referring doctor (if applicable): _____

MAIN MEMBER/PERSON RESPONSIBLE FOR ACCOUNT *(Kindly complete when this is not the patient)*

Full Name: _____

Preferred name (if different from above): _____

Title: _____ Initials: _____ Gender: M F

ID: _____

Home language: _____

Home Address: _____

_____ Postal code: _____

Postal Address (if different from above): _____

_____ Postal code: _____

Home phone: _____

Cell Phone: _____ Use this number for correspondence: Y N

E-mail: _____ Use this for correspondence/statements: Y N

Occupation: _____ Employer: _____

MEDICAL SCHEME DETAILS

Please read Dr Dower's notice regarding professional fees, displayed in reception and ask our staff if you have any questions.

Medical Scheme: _____ Plan/Option _____

Member no: _____ Gap cover: Y N M/M Dep Code _____

EMERGENCY CONTACT

In case of emergency, whom would you like us to contact? (not from the same physical address):

Name: _____ Initials: _____ Title: _____

Cell Number: _____ Relationship: _____

From time to time, we send out emails to our patients informing them of new treatments, events and information that might be of interest to them. Please let us know if you would like to receive this correspondence. Y N

PRACTICE TERMS AND CONDITIONS

PRACTICE FEES AND PAYMENT POLICY

This practice does not charge medical aid rates. These rates were unilaterally determined by the Department of Health and are known as the Reference Price List (RPL) and are available from the Department of Health (Tel: 012-3389300) and www.doh.gov.za.

This practice charges fees that are up to 3 times the RPL, depending on your individual medical aid scheme.
Any requests for payment arrangements different to those set out above, must please be discussed prior to being seen or treated by Dr Dower.

Out of Hospital

All consultations and procedures done in the rooms, are payable directly, on the day of service. The cost of these procedures will vary – an estimate can be provided beforehand on request.
All consumables used during consultations will be charged for and are payable on the day of service.
Following a procedure, there will be no charge for routine follow up appointments and you will only be billed for consumables used. If, however a complication or new clinical condition arises, this will be charged accordingly.
You will be issued with a receipt, which you may use to claim from your Medical Aid, which will reimburse you according to your choice of plan.

In Hospital

For planned in-hospital procedures, we will assist you where possible, in obtaining authorization from your medical aid.
Before surgery, we will provide you with a quotation, which will be an estimate of the surgeon's fees. This does not include the anesthetist or hospital fees, which are billed separately.
It is important to note that during surgery, interventions or actions may arise which necessitate different or additional procedures to those displayed in your quotation. If this does occur, we will adjust the claim accordingly and request retrospective authorization on your behalf. Dr Dower will always exercise his best professional judgment in making these decisions, which he deems necessary and in the best interests of you, his patient.
Where you are treated for an emergency PMB condition in-hospital, we will do our best to motivate for full payment from the medical scheme on your behalf.
This practice cannot be held responsible for any additional fees or outstanding amounts not settled by your medical aid fund.

PATIENT UNDERTAKING

FINANCIAL CONSENT

I accept that I am fully responsible for the payment of services rendered and undertake to pay all 'out of hospital' consultations and procedures immediately, and to settle all other statements on receipt thereof.
I understand that should I not pay timeously; I will be liable for Debt recovery costs including interest and a monthly service fee, as well as all legal costs incurred, on an attorney/client scale.
Furthermore, I understand that if my account is outstanding for longer than 90 days, I will be listed as a bad payer on ITC.

CONSENT FOR TREATMENT

I consent to treatment by Dr Dower.
Should I have any questions or uncertainties regarding a planned procedure or treatment, I have the right to ask Dr Dower to provide me with further information.

This may include:

- Diagnosis and prognosis (including prognosis if the condition is left untreated)
- Different treatment options available (including no treatment)
- Common and/or serious complications
- The benefits of treatment

I understand that I have the right to seek a second opinion at any time.

PRIVACY OF MEDICAL INFORMATION

I understand that this practice has implemented reasonable security measures to guard against the unauthorized disclosure of my personal information, and that I may revoke my authorization in writing at any time.

DISCLOSURE OF MEDICAL INFORMATION

I authorize:
The use and disclosure of my medical information to relevant 3rd parties, including but not limited to, referring doctors, pathologists and other medical professionals, as Dr Dower sees fit
The disclosure of relevant medical information and ICD-10 codes to my medical aid for payment of claims

I confirm that the information I have given is true and correct.
I have read and understood the terms and conditions above and agree to the patient undertaking.
I will notify the practice of any changes to my medical aid or contact details before proceeding with any further consultations or procedures.

Signature _____

Name _____

Date _____