C POINT MEDICAL PRACTICE
Dr Monya B Pelser **General Practitioner** Practice nr: 0978078
MBChB (Pret), DipPEC(SA), DMH(SA)

CONSENT FORM

FOR THE PROCESSING OF PERSONAL INFORMATION

Capitalised terms used in this consent form have the meanings ascribed thereto in section 1 of Protection of Personal Information Act 4 of 2013.

I/We, the undersigned

If legal entity:

_____ (Name of entity), with registration number:

_____ herein represented

by _____.

Or

If natural person:

_____ (Name and surname), with identity number

_____.

(Hereinafter referred to as the "Data Subject")

Hereby expressly and explicitly grant my Consent to **C POINT MEDICAL PRACTICE (PTY) LTD** ("the Company") to Process my Personal Information, on the express understanding that:

1. This constitutes the Data Subject's Consent, as required under the Protection of Personal Information Act 4 of 2013 ("POPI").

2. The Data Subject confirm that the Data Subject's Personal Information, provided is accurate, up to date, not misleading and is complete in all respects, save where same may change and then in such event, the Data Subject undertake to advise the Company or its Operator (s) of these changes.

C POINT MEDICAL PRACTICE
Dr Monya B Pelser **General Practitioner** Practice nr: 0978078
MBChB (Pret), DipPEC(SA), DMH(SA)

3. The Data Subject, in providing the required Personal Information to the Company and/or to its Operator, Consent and give the Company permission to process the Data Subject's Personal Information as and where required and acknowledge that the Data Subject understand the purposes for which the Personal Information is required and for which it will be used.

4. Furthermore, should any of the Personal Information which has been provided by the Data Subject concern or pertain to a legal entity whom the Data Subject represent, the Data subject in such event confirm that Data Subject have the necessary authority to act on behalf of such legal entity/Data Subject and that he/she has the right to provide the Personal Information and/or the required Consent to use said Personal Information, on behalf of the aforementioned legal entity.

5. Furthermore, should any of the Personal Information belong to any of my dependants and/or beneficiaries who are underage, I in my capacity as their legal guardian and Competent Person give the Company the appropriate permission to process their Personal Information for the purposes for which these details were given.

6. Lastly, the Data Subject hereby agrees to the Company's Privacy Policy, which is located on the Company's website, alternatively available upon request by the Data Subject to the Company. The Data Subject specifically agrees that they understand the terms contained in the Privacy Policy and confirm that same is binding on the Data Subject.

_____ DATE	_____ SIGNATURE

C POINT MEDICAL PRACTICE
Dr Monya B Pelser **General Practitioner** Practice nr: 0978078
MBChB (Pret), DipPEC(SA), DMH(SA)

Person responsible for account (Guarantor details):

Title:		Name:	
Surname:		ID number:	
Physical/ home Address:			
Email address:			
Cellphone nr:			
Tel (home):		Tel (Work):	

Next of Kin details:

Title:		Name:	
Surname:		Relationship:	
Physical /home Address:			
Cellphone nr:			

C POINT MEDICAL PRACTICE
Dr Monya B Pelser **General Practitioner** Practice nr: 0978078
MBChB (Pret), DipPEC(SA), DMH(SA)

Medical Aid Details:

Name:	
Plan:	
Medical aid nr:	

Dep nr:	Name	Surname	Date of birth
0			
1			
2			
3			

C POINT MEDICAL PRACTICE

Dr Monya B Pelser **General Practitioner** Practice nr: 0978078
MBChB (Pret), DipPEC(SA), DMH(SA)

I, the undersigned, am aware that the agreement is between me and C POINT MEDICAL PRACTICE PTY Ltd and not my Medical aid and C POINT MEDICAL PRACTICE I agree to be responsible for any Attorney fees and any additional fees if the account is handed over.

The responsible person hereby agrees to the following:

1. That he/she is liable for medical services rendered by the Doctor to (patient name) _____ and to the extent that is applicable, he/she the parent/legal guardian of the person to whom the medical services were rendered.
2. To promptly pay the account of the Doctor in accordance with the tariff of charges prevailing in the Doctor's practice, or as agreed upon between the parties or in the manner in which the parties have agreed.
3. To settle the Doctor's account timely and in full, as agreed irrespective of contracts, agreements, arrangements that she/he may have with any Medical scheme or third party.
4. Should the account not be settled in full within 20 business days after the medical services have been rendered by the Doctor, interest will thereafter be charged on any outstanding amount at a rate of 2% per month until the date that the account is settled in full.
5. Should the Doctor institute legal action against the responsible person for the recovering of any outstanding debts, it will be the patient's responsibility to pay all legal costs, including attorney and own client costs, collection fees and tracing fees.
6. It is acknowledged that, in accordance with the provisions of Section 53 (1) of the Health Professions Act of 1974 (duly amended) and Section 6 (c) of the National Health Act 61 of 2003 the costs associated with all medical services rendered by the Doctor, treatment and /or patient, to the extend required in law and professional ethics.
7. In the instance of legal requirements the Doctor is granted permission to disclose any information about the responsible person and/or the patient, including medical information and/or diagnostic codes, to relevant third parties (such as funders, administrators, switching companies, prescriptions to pharmacies, and the like) for purpose of processing payments of accounts in respect of medicines dispensed and/or medical services rendered to the responsible person/the patient as required by a specific Act or Statue, professional ethics or formal policy or directive applicable to the circumstances, such as disclosure of ICD-10 codes, the exact consequences of disclosing such information is unknown to the Doctor and that information relating to these consequences must be obtained by the responsible person and/or patient from the 3rd party to whom the information is disclosed .
8. The responsible person and/or patient agree that the Doctor may:

   * Make enquiries to confirm the information provided by the responsible person/patient is correct.
   * Seek information from any credit bureau when assessing the responsible person and/or patient application for credit, or any time during his/her continuing indebtedness to the Doctor including tracing and confirming his/her whereabouts.

C POINT MEDICAL PRACTICE
Dr Monya B Pelser **General Practitioner** Practice nr: 0978078
MBChB (Pret), DipPEC(SA), DMH(SA)

* Disclose the existence of his/her account to any credit bureau, sharing both positive and negative payment information about such account.

9. The responsible person and/or patient furthermore, agrees that the Doctor will be entitled to obtain and disclose the above information:

   *If the Doctor considers that it is necessary or may be of benefit to the responsible person and/or patient.

   *Where the Doctor is under a legal obligation to do so.

   *Where it is in the Doctors own or the public's interest that he/she does so.

SIGNED AND DATED AT_____

ON THIS_____DAY OF_____20____

DOCTOR NAME: Dr MB PELSER PATIENT NAME: _____

X _____ X _____

DR MB PELSER
MBCHB

Patient signature

SIGNATURE DOCTOR SIGNATURE PATIENT