TRAUMA · SHOULDER

DR RENIER KRIEL

ORTHOPAEDIC SURGEON

MBChB (Stell), MMed (Orth) (Stell), FC Orth (SA)

DISCLAIMER AND INDEMNITY

PAYMENT:

1. I agree to be personally liable for all amounts payable to Dr Renier Kriel in respect of services rendered by the practice to me or my dependents.
2. The fact that the practice may submit a claim to my medical aid on my behalf will not relieve me of my payment responsibilities.
3. I acknowledge that the costs associated with the medical services have been discussed and explained to me.
4. I agree to notify the practice of any change in my address, contact details or medical aid details.
5. I agree that in the event of any amount not being paid on the due date that the practice shall be entitled to charge interest on the outstanding amount at the maximum rate allowed in law.
6. I understand that in the event of surgery, that doctor's fees are separate from the hospital and anaesthesia charges.
7. I acknowledge that I will be liable for any bank charges levied against the practice in the event of a bank declining to honour any of my payments and I acknowledge that I shall be liable for all legal costs incurred in the recovery of any monies due by me calculated on the attorney client scale.

PROVISION OF INFORMATION:

8. I understand that the practice relies on all information provided by me in relation to my health and personal circumstances ("my personal information") to provide the medical services.
9. I confirm that all my personal information is accurate and up-to-date and that I will inform the practice immediately of any changes in my personal information.
10. I therefore agree to indemnify and hold the practice and doctors harmless against any harm, injury or liability in relation to the provision of medical services as a result of my failure to give complete and up-to-date information regarding my health and personal circumstances.
11. I confirm that I have been made aware of the practice privacy statement and my rights and obligations in respect of the personal information held by the practice, how the information will be processed and with whom it will be shared.
12. I understand and consent to the practice sharing my personal information, including my health information, with all relevant health professionals, facilities, medical aid funders and insurance companies as may be necessary for my treatment and care or for a legitimate purpose.
13. I confirm and consent to the practice communicating with me in respect of follow up appointments in electronic format and understand that I may opt out from receiving these communications.

I have read and understood this disclaimer and Indemnity and confirm that I understand my responsibilities relating to payment and provision of information as well as my rights and obligations in terms of the processing and storage of personal information by the practice.

PATIENT _____ **DATE** _____