TRAUMA · SHOULDER

DR RENIER KRIEL

ORTHOPAEDIC SURGEON

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

CONSENT TO TREATMENT

Patient full names and surname: ____________________

Patient identity number: ____________________

Patient medical scheme name and number: ____________________

I, the Patient, by signing this form, confirm that:

1. Dr Renier Kriel has spoken to me about my **health status**, i.e. how my health appears to be, or how he has evaluated my health. If another healthcare practitioner (doctor, nurse or physiotherapist, psychologist, for example) has referred me to Dr Renier Kriel, this referral was discussed with me.
2. Dr Renier Kriel has explained to me what my **options** of health care are. I understand these options and have consented to the treatment / treatment plan, described as follows: ____________________
____
3. I understand what this health care **means, and what it will take from me**. I understand that, specifically, I have to consider the following *(e.g. treatment duration, importance of taking medication, coming back to the Practice as instructed, following self-care and how I must behave or things I must not do, etc.):* ____________________
____
4. I have been told about the **benefits, risks and costs** of the health care. I understand the risks, and agree to those risks, which includes: ____________________
____________________ ____________**PATIENT INITIALS**

   I understand that the **price** related to the health care are subject to the agreement I signed with the practice when I first joined. I have been informed of the fees charged by Dr Renier Kriel, and also that certain fees and costs are excluded from that fee (e.g. hospital and diagnostic tests costs). I also understand that healthcare sometimes requires more than what was anticipated, and Dr Renier Kriel will bill for all such healthcare reasonably rendered. Some consultations are time-based, and if more time is taken to address my healthcare, such extended time will be billed for.
5. I understand that I can **refuse** health care at any stage, but also understand that if I refuse, Dr Renier Kriel must explain the consequences of the refusal to me. I will then not hold Dr Renier Kriel or the practice liable for any of those consequences, should they happen. If I refuse, I must still pay for the health care I have had up to that point.

Signed at ____________________**(place) on** ____________________**(date).**

Patient's Name: ____________________**Patient's Signature:** ____________________

Dr Renier Kriel: ____________________

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