DR. KAMAL BHANA INC
CONSULTANT DERMATOLOGIST
MScDerm (U.K.); MMedDerm (Pretoria)

DR. GILLIAN LAWRIE
CONSULTANT DERMATOLOGIST
MBChB(UKZN), DCH(SA), FCDerm(SA)

DR. BHAVNA SINGH
CONSULTANT DERMATOLOGIST
MBChB(UKZN), FCDerm(SA), MMed(Derm)

Specialist dermatologists

MEDICAL • SURGICAL • COSMETIC

56 Chelsea Drive
Durban North, 4051

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031 564 9937
065 349 8850
admin@dermatologists.co.za

PR No.0955531

PATIENT DETAILS

Title: Mr/Mrs/Ms/Dr First Names: _____

Nickname: _____ Surname: _____

Gender: ____ Age: _____ Date of Birth: _____ I.D. Number: _____

Marital Status: _____ Email Address: _____

Occupation: _____ Employer: _____

Home Address: _____ Code: _____

Postal Address: _____ Code: _____

Telephone Home: _____ Work: _____ Cell: _____

Known Drug Allergies: _____

Past Medical History: _____

General Practitioner: _____ Tel: _____

Referred by: ☐ Word of Mouth ☐ GP ☐ Internet Search ☐ Social Media ☐ Drive By ☐ Other

PERSON RESPONSIBLE FOR ACCOUNT (If different to above)

Mr/Mrs/Miss_____ First Names: _____ Surname: _____

I.D. Number: _____ Employer: _____

Home Address: _____ Code: _____

Postal Address: _____ Code: _____

Telephone Home: _____ Work: _____ Cell: _____

Medical Aid: _____ Number: _____

Main Member's Name: _____

Next of Kin: _____ Relationship: _____

Tel Home: _____ Work: _____ Cell: _____

FOR OFFICIAL USE:

_____ File Number: _____

POPSPRINT 031-3013291

Dear Valued Patient

Your healthcare is important to us. Please familiarise yourself with the contents of our Doctor-Patient Contract. This serves as a binding contract between you and this practice, Specialist Dermatologists – Dr Kamal Bhana Inc & Associates

DOCTOR PATIENT CONTRACT

CONSENT FOR TREATMENT

I (and on behalf of my child or any other person under my care) voluntarily consent to the rendering of care, including treatments, administration of anaesthetics and performance of diagnostic and/or surgical procedures by the attending/collaborative Specialist Dermatologists (herein referred to as the 'Provider') and I agree that it is the responsibility of the staff to carry out the instructions of such Provider. I understand that I am entitled to discuss the clinical aspects of my health care with the doctor or therapist and may at any stage withdraw or refuse consent and further medical care.

Any complications, side effects or reactions from therapy or procedures are to be reported to the Provider within 24 hours of occurrence as complications, side effects and reactions can be managed by the Provider. At all times the Provider may prescribe off-label, novel and newly published methods of treatment for recalcitrant disorders. I understand that the option of seeking a second opinion on any prescribed therapy is available prior to embarking on treatment with the Provider.

I am to inform the Provider if I suffer from non dermatological disorders or known to have an allergy to specific drug/s. Women of child bearing age must inform the provider if they are pregnant or planning a pregnancy within the next 12 months. It is my responsibility to follow up on the results of diagnostic procedures carried out or requested by the Provider.

PAYMENT

I, the undersigned, am responsible for the payment of the account (only persons above the age of 18). I am responsible for paying the bill directly to the Provider after being seen by the Provider, for all services rendered. The Provider will provide a detailed invoice at the end of the consultation or treatment which will be payable upon leaving the practice. The Provider is not contracted to medical aid societies. The practice charges tariffs above the scale of benefits provided for by medical aid societies. Pathology laboratory services that are required by the Provider are outsourced. The fees for their services are separate and is billed directly to the patient by the Pathology laboratory.

In the event of the Provider having to collect any amount owing by me or to take legal proceedings for the recovery of any amount arising out of this Agreement or the cancellation thereof, I shall bear the cost on an attorney and client basis. The Provider reserves the right to charge interest on outstanding accounts due from the date of the service and up to the maximum interest allowed by the Prescribed Rates of Interest Act.

NO SHOW

I understand that I am required to pay the full amount of any scheduled visit if it is not honoured, and am not available for the appointment or if I cancel with less than 48 hours notice.

RELEASE OF INFORMATION AND CONFIDENTIALITY

I hereby acknowledge that I have read and agree to the Practice Privacy Statement which may be found on the Providers website www.dermatologists.co.za. ⟶ Forms ⟶ POPIA consent form

COVID 19

I am visiting Specialist Dermatologists with full knowledge that there is currently a COVID-19 global pandemic. There is a possible risk of contracting this virus by visiting any place during this pandemic. I hereby absolve the provider of any criminal or medico legal liability arising from my voluntary visit to Specialist Dermatologists.

GENERAL RELEASE

The Provider's liability to me for any indemnity commitments or for any damages arising in any way out of the performance of his or his employee's duties and this contract is limited to insurance coverage and amounts taken out by the Provider. In no event will the Provider be liable for any indirect, special or consequential loss or damage arising from the performance of services including, but not limited to, loss of use, loss of profit, economic damages, guilt and suffering, whether caused by the negligence of the Provider, or otherwise, and I, shall indemnify (cover) and hold the Provider harmless from any such damages or liability which is limited to insurance coverage of the Provider.

I hereby undertake to ratify whatever the Provider shall lawfully do or cause to be done pursuant to this agreement and to further indemnify the Provider against any loss or claims whatsoever which may arise from the management of the patient, including loss arising from any act or omission by the employees of the Provider.

I hereby acknowledge that I have read and agree to the above and that all the information submitted by me is true and correct.

Date	Name in full	Signature