National Radiology Services

Drs. Ranchod and Jogi Inc. • Reg. No: 2004/009411/21

DIAGNOSTIC RADIOLOGISTS | DIAGNOSTIESE RADIOLOË | UDOKOTELA WE-XRAY

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VAT No: 4840211868 • PR No: 038 000 014 5459 • BBBEE Status Level 2

Save As

DATE / DATUM: D D M M Y Y Y Y

PATIENT INFORMATION / PASIËNT BESONDERHEDE

TITLE / TITEL | INITIALS / VOORLETTERS | REL. TO MEMBER / VERW. AAN LID | FIRST NAMES / EERSTE NAME

SURNAME / VAN | LANGUAGE / TAAL | GENDER / GESLAG: Select | I.D. NUMBER / I.D. NOMMER

DATE OF BIRTH / GEBOORTE DATUM: D D M M Y Y Y Y | EMPLOYER / WERKGEWER

HOME / HUIS ☎ | WORK / WERK ☎ | FAX

CELL / SEL ☎ | E-MAIL ADDRESS / E-POS ADRES

ALLERGIES? / ALLERGIEË?: Select | PLEASE SPECIFY / SPESIFISEER

REF. DOCTOR / VER. DOKTER | AUTH. NO. / MAGT. NR.

ARE YOU PREGNANT? / IS U SWANGER?: Select | KIDNEY FAILURE? / NIER VERSAKING?: Select | ASTHMA? / ASMA?: Select | ARE YOU BREASTFEEDING? / BORSVOED U?: Select | SMOKING? / ROOK?: Select

HIGH BLOOD PRESSURE? / HOË BLOEDDRUK?: Select | WORK UNDERGROUND? / ONDERGRONDS WERK?: Select | PATIENTS NOTES / PATIËNT NOTAS

PREVIOUS OPERATIONS? / VORIGE OPERASIES?

PERSON RESPONSIBLE FOR PAYMENT / PERSOON VERANTWOORDELIK VIR BETALING

TITLE / TITEL | INITIALS / VOORLETTERS | REL. TO PATIENT / VERW. AAN PASIËNT | FIRST NAMES / EERSTE NAME

SURNAME / VAN | LANGUAGE / TAAL | GENDER / GESLAG: Select | I.D. NUMBER / I.D. NOMMER

DATE OF BIRTH / GEBOORTE DATUM: D D M M Y Y Y Y | EMPLOYER / WERKGEWER

HOME / HUIS ☎ | WORK / WERK ☎ | FAX

CELL / SEL ☎ | E-MAIL ADDRESS / E-POS ADRES

POSTAL ADDRESS / POSADRES	RESIDENTIAL ADDRESS / WOONADRES
CODE / KODE	CODE / KODE

MED. AID NAME / M. FONDS NAAM | MED. AID NO. / M.FONDS NR.

B.A.D. / W.C.A./M.V.A.: Select | DATE OF INJURY / DATUM VAN BESERING: D D M M Y Y Y Y | CLAIM NUMBER / EIS NOMMER | EMPLOYEE NO. / WERKGEWER NR.

EMPLOYERS ADDRESS / WERKGEWER ADRES	RELATIVE OR FRIEND / FAMILIELID OF VRIEND
	NAME / NAAM
	HOME / HUIS ☎
CODE / KODE	CELL / SEL ☎

METHOD OF PAYMENT (Please Tick) / BETAAL METODE (Merk Asseblief) | CREDIT CARD / KREDIET KAART | CASH / KONTANT | CHEQUE / TJEK: Select

TERMS: STRICTLY 30 DAYS / TERME: STRENG 30 DAE

DECLARATION / VERKLARING

PLEASE NOTE: NOT RESPONSIBLE FOR LOSS OF VALUABLES

LET WEL: NIE VERANTWOORDELIK VIR VERLIES VAN WAARDEVOLLE ARTIKELS

Constitutional requirements necessitate that all patients acknowledge our term of service.

I, _____ the undersigned do hereby agree that:

1. I give consent to the injection of any drug or Contrast Media, which may be necessary for the performance of the examination. I understand the possibility of negative effects and loss of concentration caused by sedation.
2. I hereby declare that I am the legal guardian/custodian of the above child and understand and accept the contract.
3. I undertake to be liable for all legal costs/ fees, necessary for the recovery of payment.
4. I accept personal responsibility for the payment of the account to the practice whether authorization was granted by my medical aid or not. Pre- authorization does not guarantee payment.
5. In case of non-payment, the undersigned accept the responsibility of payment and interest in collecting the outstanding fees as laid down by the "Health Professions Council of South Africa"
6. The ICD10 code states the diagnosis in a coded format. I hereby consent to the submission of my ICD10 code to my referring doctor and medical aid.

Konstitisiële vereistes, bepaal dat alle pasiënte die terme van dienste gelewer, erken

Hiermee aanvaar ek, _____ die ondergetekende die volgende:

1. Ek gee hiermee toestemming vir die inspuit van Kontras Media, of enige ander medikasie wat nodig mag wees tydens die ondersoek. Ek is bewus van moontlike newe-effekte en die uitwerking daarvan, en sal nie bestuur of enige masjinerie hanteer, vir ongeveer 8 ure na toediening van 'n sedasie middel nie.
2. Ek bevestig hiermee dat ek die voog van die bogenoemde kind is en verstaan en aanvaar die kontrak.
3. Die ICD 10 kode, beskryf die diagnose in 'n kode formaat. Ek gee hiermee toestemming dat dit bekend gemaak mag word aan die mediese fonds asook die verwysende dokter.
4. Ek aanvaar persoonlike verantwoordelikheid vir die rekening, met magtiging toegestaan deur die mediese fonds of nie. Magtiging waarborg nie betaling nie.
5. In die geval van nie-betaling, aanvaar die ondergetekende die verantwoordelikheid van betaling en rentes soos bepaal deur die "Health Professions Council of South Africa".
6. Ek onderneem om verantwoordelikheid te aanvaar vir enige regskostes wat aangegaan kan word om die gelde in te vorder.

Signature: / Handtekening: _____ Date: / Datum: _____ Place: / Plek: _____

Save As

NB.: ALL PATIENTS WILL BE HELD RESPONSIBLE FOR ACCOUNT UNTIL SETTLED - TERMS STRICTLY 30 DAYS
L.W.: ALLE PASIËNTE IS VERANTWOORDELIK VIR REKENING TOT AFGEHANDEL - TERME STRENG 30 DAE