parklane radiology

Integrated Radiology Services cc

Patient Information (as it appears on medical aid card)					
Name:		Surname:			
Title:	Initials:	Sex:		Age:	
Date of birth: (dd/mm/yyyy)		I.D. no:			
Relation to member:		Dependent code:			
Home Telephone no:		E-mail address:			
Physical Address:		Cellphone no:			
		Postal Address:			
	Code:			Code:	
Referring doctor:					

Person Responsible for Payment - Main Member (as it appears on medical aid card)					
First Name + Surname:				Mr/Mrs:	
Date of Birth:		I.D. No:			
Relation to Member:		Dependent code:			
Employer:					
Work Telephone no:		Work Address:			
Fax no:				Code:	
Cell. no:		Medical Aid Plan Name:			
Medical Aid no:		Medical Aid:			

Do you suffer from Asthma?	Yes		No		
Allergies:		Please specify:			

Female patients:	Are you pregnant?	Yes		No	

Contact details of Relative/Friend					
Name + Surname		Cellphone no:			
Physical Address:				Code:	

Payment - Terms-strictkly 30 days					
Method of payment					
Medical Aid					
Credit Card		Cash			

Payment of the account in accordance with tariff of charges prevailing in the practice shall be the responsibility of the undersigned/patient.

In the event of the account not being timeously settled in full by the patient/undersigned and/or the relevant medical aid, then interest at a rate equal to 2% per month on the outstanding balance will be payable there on, until the date on which it is settled in full.

I undertake to be liable for all legal costs between attorney and client as well as tracing and collection fees due should it be necessary for legal action to be taken for the recovery of any amount owing arising out of treatment received by the above patient.

I consent to your being entitled to obtain credit and related information concerning myself at any time and/lodge, exchange and disclose such information with any credit bureau without any further notice to me.

I further consent to your being entitled to disclose any medical information regarding the above patient to my medical aid, as they require. I confirm that I am aware that the practice may make the X-ray and other digital images taken by the practice, available in a digital electronic form to medical practitioners,

Date: _____ Full name: _____ Signed: _____

For Office use only		
Date:	Account no:	File no:
Examination:		
Pre-Authorised:		Capturedby:

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