Dr Murray Davidson

Specialist Cardiothoracic Surgeon

MB.,ChB. (Stell) FC Cardio (SA). PR: 0383392

Life The Glynnwood Hospital

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Email: drdavidson@vodamail.co.za

www.drdavidson.co.za

PATIENT DETAILS:			
First Name(s):		Surname:	
ID Number:		DOB:	
Title:		Language:	
Cell:		Home Tel:	
Work Tel:		Occupation:	
Email:			
Home Address:			
Postal Address:			

MEDICAL AID (SCHEME) DETAILS:			
Name:		Plan:	
Number:		Dependent:	
Main Member Full Name & Surname:		Main Member ID Number:	
Cell:		Home Tel:	
Work Tel:		Occupation:	
Email:			
Home Address:			
Postal Address:			

I understand that in order for Dr MB Davidson to claim from my medical aid (scheme,) certain information relating to my diagnosis will be shared with my medical scheme. Regulation 5 (f) of the Medical Schemes Act (published in the Government Gazette No 20556 on the 20 Oct 1999) states that any account submitted to a medical aid must contain the relevant diagnosis. This must be submitted as an ICD-10 diagnostic code. If this information is not shared, then my medical scheme will not honour the doctors account, nor will they provide authorisation for hospital admission or a procedure to be performed.

I further acknowledge and note that when my medical scheme provides a copy of my account to the main member of the scheme, that my personal information and diagnosis (in the form of the ICD-10 diagnostic codes on the account) will be indirectly shared with the main member.

I hereby consent that my protected medical information, diagnosis & ICD-10 coding may be shared by Dr MB Davidson and / or his authorized staff with my Medical Aid as detailed above.	Yes	No
	Initial:	
I hereby authorise Dr MB Davidson and / or his authorized staff to handle any disputes on my behalf regarding Dr Davidson's Account with my medical scheme and / or it's administrators and / or with the Council of Medical Schemes, should the need arise.	Yes	No
	Initial:	

YOUR MEDICAL AID: WHAT DOES YOUR MEDICAL AID COVER?

Your treatment, the financial cost thereof, and the quality of your professional care can be severely affected by your Medical Aid and the type of medical plan that you belong to, and the generalisation of statements such as "100% cover" by your medical aid that may or may not correspond with all the aspects of the treatment that you may require.

These limitations often prove problematic for your doctor as your right to obtain the necessary professional medical treatment that meets an acceptable standard of care is being influenced by your choice of medical aid cover. It remains your primary responsibility to familiarise yourself with the benefits and conditions of your medical aid plan. It is important that you know your benefits with regard to the extent of your health cover, referral restrictions, savings account balances, pre-authorisation processes, waiting periods and other requirements.

Where a Designated Service Provider has been appointed by your medical aid, it remains your responsibility to be cognisant of this and to bear responsibility for any restrictions that may follow, either medically or financially, when consulting a “Non-Designated” doctor or facility. The Medical Schemes Act 131 of 1998 and its regulations entitle members of a medical scheme to all the information on their benefits and limitations of their plan.

You are responsible to acquaint yourself with the benefits, insured rates, and terms and conditions of your medical scheme plan. You should ascertain the exact amounts that your scheme provides for in terms of consultations, procedures, assistants and prosthesis limits; including what your medical aid will pay for and not pay for.

With ever increasing intervention from your medical scheme, please be aware that Dr Davidson does not allow a medical scheme to violate his professional and clinical independence. Please note that Dr Davidson practises medicine and Cardiothoracic Surgery according to International Best Practice and he will not deviate from his standard of care to suit your medical aid. This includes the performance of minimally invasive (VATS or Thoracoscopic) surgery where possible, and the use of Precedex for sedation in ICU, amongst others. This may or may not have a financial implication for you depending on your medical scheme and plan. The onus remains on you to confirm what your medical aid does- or does not cover.

Where a medical aid or its advisors intervene to overrule your doctors preferred diagnostic or treatment approach, and/or treatment, your doctor assumes no responsibility for any consequent adverse outcomes or the financial consequence thereof. You may be asked to assume responsibility for the medical aid and it's medical advisors in the event of complications.

PRE-AUTHORISATION

If for your treatment, hospitalisation is required. It remains your responsibility to ensure that the planned treatment is covered by your medical aid and that the necessary finances are put into place to cover the non-insured costs. You are always welcome to ask the rooms for a quote for the Doctors portion of the procedure. If pre-authorisation is required for any intervention, Dr Davidson and his staff may assist you in this process; but it remains your responsibility to confirm what your medical aid will cover and to furnish the practice with the relevant information and authorisation numbers. Where your medical aid questions the appropriateness of your treatment, Dr Davidson may submit a letter of motivation to the medical scheme if appropriate and at your cost. Dr Davidson may further insist on a peer-to-peer discussion in the above instance.

_____ **(Initial)**

DR DAVIDSON’S ACCOUNT

- I acknowledge that Dr Davidson, in the absence of any Pre-Signed Agreement or Contract with your Medical Aid, bills all accounts out at **217%** of the Medical Aid rate; and in accordance with the guidelines of the Health Professionals Council of South Africa (HPCSA) and the Society of Cardiothoracic Surgeons of SA.
- **Please note that in accordance with the Society of Cardiothoracic Surgeons of South Africa Billing Guidelines, management in an Intensive Care Unit (ICU) or High Care is not deemed part of “Routine” Post-Operative Care. This has reference with regards to Rule G of the Billing Guidelines. Furthermore, as per Rule J, “Ventilation” is not deemed part of “Routine” Post-Operative Care. Thus in accordance with the above, Dr Davidson bills for all visits and care given in an Intensive Care or High Care Setting. I acknowledge that my Medical Aid may or may not agree with these guidelines but that I will remain liable for the full cost thereof in the event of any shortfall or non-payment.**
- This practice submits accounts subject to the National Credit Act, the Consumer Protection Act, the Medical Schemes Act and the guidelines as published by the HPCSA & the Society of Cardiothoracic Surgeons of South Africa.
- I acknowledge that the account is rendered completely separate from that of the hospital and any other medical accounts.
- I acknowledge that I am personally responsible for the payment of Dr Davidson’s account and that it is my responsibility to claim my refund from the medical aid. I acknowledge that even though Dr Davidson may submit my bill electronically on my behalf to my medical aid; that I will remain responsible for the full payment of Dr Davidson’s account in the event of any non-payment and/or shortfall.
- This practice reserves the right to claim directly from you in which case you will be provided with a detailed invoice that is payable to the practice within 30 days from the date of service. You have the right to claim this back from your medical aid.
- You, the main member of your medical aid, and/or your parent/guardian remain at all times liable for the payment of all services rendered by this practice even if you are insured by a medical aid or another third party. This agreement does not preclude the practice from taking all reasonable and practical steps to recover any outstanding amounts from you.
- I acknowledge that Dr Davidson will not enter into any negotiation with the medical aid on my behalf.
- This practice reserves the right to charge a service fee for any credit given in terms of the provisions of the National Credit Act, Act No. 34 of 2005. In terms of section 101 (1) (c), an initial per transaction service fee may be charged on the transactions for which a credit amount is provided and thereafter on a monthly basis for each month that a credit balance remains. In terms of section 101 (1) (d), interest may be charged on the account for each month that the credit amount is not paid by you.
- Where legal action is instigated for the recuperation of costs for services rendered or goods provided for, then in terms of section 101 (1) (g) collection costs may be imposed to the extent permitted by Part C of Chapter 6 of the National Credit Act, Act no 34 of 2005.
- Dr Davidson reserves the right to charge interest on your outstanding accounts due from the date of service up to the maximum interest allowed for in terms of section 2 of the Prescribed Rate of Interest Act.
- It remains your responsibility to inform and update the practice of all your personal and medical aid details. You hereby undertake to keep the practice regularly informed with regards to any changes in your contact details, benefits and list of dependants.
- Please note that the use of someone else's medical aid card with or without such a person's consent or knowledge constitutes fraud. This practice will report such instances to the medical aid concerned to protect the practice from being regarded as cooperative in such fraudulent practice.

_____ **(Initial)**

NEXT OF KIN OR EMERGENCY CONTACT:			
FIRST NAME(S):		**SURNAME:**	
TITLE:		**RELATIONSHIP:**	
CELL:		**ALT. TEL:**	
EMAIL:			

I HEREBY CONSENT THAT MY PROTECTED MEDICAL INFORMATION MAY BE SHARED BY DR MB DAVIDSON OR HIS AUTHORIZED STAFF WITH MY AFOREMENTIONED NEXT OF KIN OR EMERGENCY CONTACT.	**YES**	**NO**
	INITIAL:	

PLEASE INDICATE WHETHER YOU GIVE PERMISSION FOR THE FOLLOWING SPECIFIC INFORMATION TO BE DISCLOSED:

HIV TEST RESULTS:	**YES**	**NO**	ALCOHOL, SMOKING &/OR DRUG USAGE:	**YES**	**NO**	MENTAL HEALTH ILLNESS:	**YES**	**NO**

NEXT OF KIN OR RESPONSIBLE PARTY:			
FIRST NAME(S):		**SURNAME:**	
TITLE:		**RELATIONSHIP:**	
CELL:		**ALT. TEL:**	
EMAIL:			

I HEREBY CONSENT THAT MY PROTECTED MEDICAL INFORMATION MAY BE SHARED BY DR MB DAVIDSON OR HIS AUTHORIZED STAFF WITH MY AFOREMENTIONED NEXT OF KIN OR RESPONSIBLE PARTY.	**YES**	**NO**
	INITIAL:	

PLEASE INDICATE WHETHER YOU GIVE PERMISSION FOR THE FOLLOWING SPECIFIC INFORMATION TO BE DISCLOSED:

HIV TEST RESULTS:	**YES**	**NO**	ALCOHOL, SMOKING &/OR DRUG USAGE:	**YES**	**NO**	MENTAL HEALTH ILLNESS:	**YES**	**NO**

GENERAL PRACTITIONER:			
NAME:		**SURNAME:**	
TITLE:		**TEL:**	
EMAIL:			
PRACTICE ADDRESS:			

PLEASE NOTE THAT WITH YOUR APPROVAL, DR MB DAVIDSON WILL PROVIDE YOUR GP AND ALL INVOLVED SPECIALISTS WITH A COPY OF YOUR MEDICAL REPORT WITH THE PERTINENT OPERATIVE FINDINGS, A COPY OF YOUR HISTOLOGY REPORT AND YOUR MOST CURRENT TREATMENT PLAN UPON DISCHARGE FROM HOSPITAL AND COMPLETION OF THE REPORT. I HEREBY CONSENT THAT MY PROTECTED MEDICAL INFORMATION MAY BE SHARED BY DR MB DAVIDSON OR HIS AUTHORIZED STAFF WITH MY GENERAL PRACTITIONER AND / OR ANY INVOLVED SPECIALISTS FOR THE PURPOSE OF CONTINUATION OF MY CARE.	**YES**	**NO**
	INITIAL:	

MEDICAL ("SICK") CERIFICATES:

PLEASE NOTE THAT THIS PRACTICE WILL ONLY PROVIDE MEDICAL (SICK) CERTIFICATES SHOULD YOUR SPECIFIC CONDITION SO WARRANT. IF A DIAGNOSIS IS PROVIDED ON THE MEDICAL CERTIFICATE, THE CERTIFICATE WILL ONLY BE HANDED OR EMAILED TO YOU, UNLESS OTHERWISE REQUESTED BY YOU IN WRITING. IT REMAINS AT YOUR DISCRETION TO DISCLOSE YOUR ILLNESS, CONDITION OR DIAGNOSIS TO YOUR EMPLOYER. IF YOU OR YOUR EMPLOYER IS CONSIDERING CLAIMING FOR A DISABILITY, THEN YOU MAY BE REQUIRED TO DISCLOSE THE NATURE AND EXTENT OF SUCH A DISABILITY (AND YOUR DIAGNOSIS) TO YOUR EMPLOYER AND THE INSURANCE COMPANY.

INITIAL:

PROTECTION OF PERSONAL INFORMATION:

DR MB DAVIDSON, AND HIS PRACTICE STAFF, HEREBY UNDERTAKE TO COMPLY WITH ALL THE PROVISIONS OF THE PROTECTION OF PERSONAL INFORMATION ACT NO 4 OF 2013 (HEREINAFTER REFERRED TO AS POPIA,) AS WELL AS ANY AMENDMENTS THERETO. DR MB DAVIDSON, AND HIS PRACTICE STAFF, HEREBY UNDERTAKE THE FOLLOWING:

1. TO TREAT ALL YOUR PERSONAL INFORMATION AS STRICTLY CONFIDENTIAL. DR MB DAVIDSON, AND HIS PRACTICE STAFF, WILL NOT DIVULGE ANY SAID INFORMATION TO ANY OTHER THIRD PARTIES OR PEOPLE OTHER THAN THOSE THAT HAVE BEEN AGREED TO WITHIN THIS AGREEMENT;
2. TO MAINTAIN REASONABLE SECURITY MEASURES AS REQUIRED BY SECTION 19 OF POPIA IN RELATION TO ANY PERSONAL INFORMATION THAT IS IN OUR POSSESSION IN TERMS OF THIS AGREEMENT; AND
3. TO NOTIFY YOU, AS SOON AS IS REASONABLY POSSIBLE AND IN ACCORDANCE WITH THE NEEDS OF LAW ENFORCEMENT, IF THERE ARE REASONS TO BELIEVE THAT YOUR PERSONAL INFORMATION HAS BEEN ACCESSED OR ACQUIRED BY ANY PERSON OR PARTY NOT AUTHORISED TO HAVE ACCESS THERETO WITH RESPECTS TO THIS AGREEMENT.

IN RESPECT OF THIS AGREEMENT, PLEASE NOTIFY ALL OF YOUR FRIENDS AND FAMILY MEMBERS PRIOR TO BEING ADMITTED, THAT DR MB DAVIDSON, AND HIS PRACTICE STAFF, WILL ONLY DISCUSS THE PERTINENT FACTS REGARDING YOUR HEALTH, OPERATIVE FINDINGS AND FURTHER MANAGEMENT WITH YOUR DESIGNATED NEXT OF KIN OR RESPONSIBLE PARTY AS AGREED TO IN TERMS OF THIS AGREEMENT.

I HEREBY CONSENT TO THE PROCESSING AND STORAGE OF MY PERSONAL INFORMATION WITH REGARDS TO THE PROTECTION OF PERSONAL INFORMATION ACT NO 4 OF 2013, BY DR MB DAVIDSON, HIS PRACTICE STAFF, AND ALL THIRD PARTIES WITH WHOM DR MB DAVIDSON HAS A CONTRACTUAL RELATIONSHIP WITH FOR THE FOLLOWING PURPOSES: 1. TREATING AND MANAGING ME IN TERMS OF A DOCTOR-PATIENT RELATIONSHIP; 2. THE ADMINISTRATION OF THE CONTRACTUAL RELATIONSHIP BETWEEN MYSELF AND DR MB DAVIDSON; 3. COMMUNICATING WITH OTHER HEALTHCARE PROFESSIONALS, MY DESIGNATED FAMILY MEMBERS OR RESPONSIBLE PARTIES IN AS MUCH AS IT RELATES TO MY TREATMENT AND MANAGEMENT; 4. COMMUNICATING WITH THIRD PARTIES WHO HAVE UNDERTAKEN TO INDEMNIFY ME FOR THE COSTS OF MY TREATMENT AND MANAGEMENT, OR PART THEREOF, INCLUDING MY MEDICAL SCHEME(S) AND THEIR ADMINISTRATORS WHERE RELEVANT; AND 5. FOR COLLECTING MONIES OUTSTANDING FROM ME, INCLUDING THIRD PARTY DEBT COLLECTORS.	**YES**	**NO**
	INITIAL:	

I HEREBY CONSENT THAT MY PROTECTED MEDICAL INFORMATION MAY BE SHARED BY DR MB DAVIDSON OR HIS AUTHORIZED STAFF WITH ANY NECESSARY HEALTHCARE PROFESSIONALS (DOCTORS OR ANCILLARY STAFF) NEEDED FOR THE PURPOSE OF THE CONTINUATION OF CARE OR THE MANAGEMENT OF MY ILLNESS.	**YES**	**NO**
	INITIAL:	

I HEREBY CONSENT THAT MY MEDICAL INFORMATION AND RECORDS (INCLUDING INTRA-OPERATIVE PHOTOS OR VIDEOS, AND / OR RADIOLOGY IMAGES) MAY BE UTILIZED BY DR MB DAVIDSON FOR THE PURPOSES OF TEACHING, RESEARCH AND / OR SCIENTIFIC PUBLICATION; ONLY IF THE RECORDS ARE ANONYMISED. (THAT MEANS YOUR NAME, ID NUMBER AND ANY OTHER IDENTIFYING DATA WILL NOT BE USED OR PUBLISHED.)	**YES**	**NO**
	INITIAL:	

THE HPCSA ETHICAL GUIDELINES MANDATE THAT ALL MEDICAL RECORDS ARE RETAINED FOR A MINIMUM OF SIX (6) YEARS AFTER ONE'S LAST CONSULTATION. GIVEN THE NATURE OF CARDIAC SURGERY AND THE IMPORTANCE OF KNOWING THE DETAILS OF PRIOR PROCEDURE(S) IN POTENTIALLY PLANNING A FURTHER INTERVENTION IF REQUIRED, AS WELL AS THE OFTEN LONG INTERVAL(S) (POSSIBLY 10-20 YEARS) BETWEEN CARDIAC SURGICAL INTERVENTIONS, IT BECOMES IMPORTANT TO RETAIN YOUR MEDICAL INFORMATION FOR A PERIOD LONGER THAN PRESCRIBED. IN LIGHT OF THE ABOVE, I HEREBY AUTHORIZE DR MB DAVIDSON TO RETAIN MY MEDICAL RECORDS FOR LIFE, OR UNTIL FORMALLY REQUESTED IN WRITING TO REMOVE THEM; BARRING THAT ALL LEGAL GUIDELINES IN TERMS OF MINIMUM DURATION OF STORAGE HAVE BEEN MET.	**YES**	**NO**
	INITIAL:	

I ACKNOWLEDGE THAT DR DAVIDSON MAKES USE OF THE BILLING COMPANY, MEDCLAIMS SOLUTIONS, TO MANAGE, PROCESS AND BILL ALL OF HIS ACCOUNTS. I HEREBY AUTHORIZE DR DAVIDSON AND/OR HIS STAFF TO SHARE ALL OF THE NECESSARY INFORMATION, INCLUDING MY PERSONAL INFORMATION, DIAGNOSIS AND ICD-10 DIAGNOSTIC CODES, WITH MEDCLAIMS SOLUTIONS FOR THE PURPOSE OF BILLING AND SUBMITTING DR MB DAVIDSON'S ACCOUNT TO MY MEDICAL AID. MEDCLAIMS SOLUTIONS AND THEIR STAFF HAVE CONFIRMED THAT ALL OF YOUR INFORMATION WILL BE REGARDED AS PRIVATE AND STRICTLY CONFIDENTIAL, AND THAT THEY WILL PROCESS YOUR INFORMATION IN ACCORDANCE WITH THE PROTECTION OF PERSONAL INFORMATION ACT.	**YES**	**NO**
	INITIAL:	

I UNDERSTAND THAT DR DAVIDSON CANNOT MAKE ANY GUARANTEES REGARDING A CURE FOR MY CONDITION. I HEREBY CONSENT TO THE PERFORMANCE OF A CLINICAL EXAMINATION ON MYSELF; APPROPRIATE TO MY PRESENTING COMPLAINT(S).	**YES**	**NO**
	INITIAL:	

PERSONAL INFORMATION:	
ALLERGIES:	

PLEASE CONFIRM ALL KNOWN COMORBIDITIES (CHRONIC ILLNESSES) WITH A CROSS (X) BELOW:

HYPERTENSION		DIABETES MELLITUS		THYROID		HIGH CHOLESTEROL	
HIV		COPD / EMPHYSEMA		ASTHMA		HAYFEVER / SINUSITIS	
CURRENT OR PREVIOUS TUBERCULOSIS (TB)				GOUT		EPILEPSY	
GASTRIC REFLUX, ULCERS OR HIATUS HERNIA				ANXIETY DISORDER		DEPRESSION	

OTHER:	

PLEASE LIST ALL MEDICATION (INCLUDING HOMEOPATHIC OR OTHER) & DOSES THAT YOU ARE PRESENTLY TAKING:

I ACKNOWLEDGE THAT ANY OMISSIONS IN TERMS OF MY KNOWN ALLERGIES, CHRONIC CONDITIONS AND/OR MEDICATION USED, MAY HAVE SERIOUS ADVERSE (EVEN LIFE THREATENING) CONSEQUENCES ON MY SUBSEQUENT TREATMENT, AND I WILL NOT HOLD DR DAVIDSON LIABLE FOR ANY OMISSIONS THAT I HAVE MADE.	**YES**	**NO**
	INITIAL:	

I HEREBY ACKNOWLEDGE WITH MY SIGNATURE BELOW AND MY INITIALS THROUGHOUT THE FORM THAT I HAVE UNDERSTOOD THIS AGREEMENT, AND THAT I HAVE HONESTLY COMPLETED ALL OF THE REQUESTED INFORMATION.

SIGNATURE:		DATE:	
WITNESS SIGNATURE:		DATE:	