



File No: _____ (Office purposes)

PARTICULARS OF PATIENT

SURNAME _____ NAME _____ INITIALS _____ TITLE _____ GENDER _____

DATE-BIRTH _____ ID NO. _____

TEL: (H/C) _____ (W) _____

RESIDENTIAL ADDRESS _____ E-MAIL _____

Principal member / dependent on scheme? _____ DEPENDENT CODE: _____

I hereby accept that email and or sms messages may be sent to me in order to confirm appointments and convey general information of the practice and my healthcare.

OCCUPATION : _____ EMPLOYER _____

REFERRED BY _____

NAME, ADDRESS & TEL NO. OF A FAMILY MEMBER _____

PAYMENT OPTIONS:

- Medical Aid Scheme Private Patient- Electronic Funds Transfer / Cash
(Total fee R950 per consultation).

MAIN MEMBER OF MEDICAL SCHEME (PERSON RESPONSIBLE FOR ACCOUNT)

(Please note that all adults are responsible for their own accounts, even if they are dependents on someone else's scheme)

SURNAME: _____ NAME: _____ INITIALS: _____ TITLE _____ GENDER _____

DATE OF BIRTH _____ ID NO _____ OCCUPATION _____

EMPLOYER (CO
NAME) _____ ADDRESS _____

TEL: (H) _____ (W) _____ (C) _____ EMAIL _____

MEDICAL SCHEME _____ NO _____ OPTION _____

Time for restoration.

HPCSA No. PS0137731 | Practise No. 0785253

+27 (0)66 213 6887 | info@johannkrynauw.co.za | 1st Floor, Cape Gate Oncology Centre, Cnr Tiger Avenue and Bisset Street, Cape Gate, Brackenfell

www.johannkrynauw.co.za



TERMS & CONDITIONS OF THE PRACTICE

By signing this form, you acknowledge that you have understood and agreed to the following:

- 1) That you have received a copy of the terms and conditions and have had an opportunity to ask questions on aspects thereof that you were not certain about.
- 2) My practice is contracted to most medical aids and fees are charged according to standard medical aid rates. If you want us to claim directly from your medical aid kindly make sure that you have sufficient funds available before you arrive for your consultation.
- 3) Patients are responsible to inquire and contact about how many sessions they have available/left that was approved directly to their own medical aid throughout our therapy sessions before arriving for sessions. In the event that your medical aid does not pay the claim, you will remain responsible for the account.
- 4) Private patients must settle the account within 24 hours after invoice for services has been send.
- 5) Interest and admin fees will be charged after 30 days. Accounts overdue by 90 days will be handover. All cost regarding this matter is the responsibility of the patient or main member.
- 6) To abide by the terms and conditions of the practice, in particular the provisions on the payments of accounts.
- 7) Each consultation is scheduled for **50 minutes per session**.
- 8) For the first session a complete Psychological Assessment will be conducted. It is important to know that the first consultation is not a therapy session but a complete Psychological History Intake Assessment.
- 9) To always ask, even after you have left the practice if you were uncertain about something. If you keep quiet, practice staff and the psychologist will assume that you have understood everything and are in agreement with any processes, consents, policies or forms.
- 10) We have a 24 hour cancellation policy, so if appointments are not cancelled 24 hours before hand the full tariff will be charged.

PSYCHOLOGIST SIGNATURE

DATE

PATIENT / ACCOUNT HOLDER SIGNATURE

Time for restoration.

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