



DR R O A RAMMUTLA

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FINANCIAL POLICY AND YOUR RESPONSIBILITY

Due to increasing problems experienced with medical aid schemes, we would like to draw your attention to our current financial policy. This policy revokes all previous financial policies.

The main member of the medical aid scheme is **liable** for the payment of the account, irrespective of the benefit structure of his/her medical aid scheme.

Your account is payable within **60** days. It is your responsibility to ensure that the medical aid scheme has paid your account on time. We will accept no verbal agreement or promises of payment; we will accept proof of payment.

To assist you in receiving your legitimate benefits from your medical aid we will continue to submit a copy of your account to your medical scheme every month. This is to help you to speed up the processing of your claims.

However, it remains your responsibility to make sure that your medical scheme has received your account. **We do not provide proof of delivery of accounts.** It remains your responsibility.

We will mail an account to you so you can check the status of your account. The onus is on you to inform us if you have not received an account. It remains **your responsibility** to check your account **and to ensure that the fund receives your account and that payment is affected within the prescribed period. Our financial policy is in force as if you received an account.**

We will provide the necessary reports and quotes to you to enable you to ascertain benefits and authority to utilize your available funds. It remains your responsibility to establish beforehand what funds are available for any prosthesis etc, to calculate your own liabilities.

All amounts that are not paid within 90 days **are automatically handed over** for debt collection. Kindly take note that this process occurs automatically and that you will not be contacted in this regard.

In the event that legal action is taken in order to collect overdue payments, you will be held liable for all legal costs. Should it be deemed necessary to hand over your account, you will be liable for the full costs of your account and all monies due to the practice at that point.

If this prescribed financial policy is not adhered to I will reserve all rights to stop any **active treatment** and only render **emergency services** on a **cash only basis.**

I understand that I am fully responsible for my account and not my medical aid. I understand that I am given 60 days in which to settle my account in full. I understand that if payment is not made within 90 days, the account will be handed over to our Attorneys for collections.

I agree that all amounts owing will immediately become due and payable and the Neuro Surgeon or their nominated representative may access any of my available information and disclose my failure to pay or erratic payments to any credit bureaus or 3rd party without incurring any liability therefore I will also be liable for interest, tracing fees, legal costs and collections fees.

Name: _____

Surname: _____

Signature: _____

Date: _____