DR R O A RAMMUTLA

Specialist Neurosurgeon MBChB (NATAL), FC(SA)

PR no: 0240000242098

Netcare Sunward Park Hospital
C/O Kingfisher Avenue, Aquarius Rd & Bert Lacey Drive
Sunward Park 1459
Tel:(011) 897 1785 Fax:(011) 897 1755
E-mail: accounts.drrammutla@mweb.co.za

Netcare Linksfield Hospital
24-12th Avenue
Linksfield 2192
Tel:(011) 647 3505 Fax:(011) 897 1755
E-mail:drrammutla@mweb.co.za

PATIENT DETAILS:

SURNAME: _____ **FULL NAME:** _____
I.D. NO: _____ **HOME NUMBER:** _____
CELL NUMBER: _____ **EMAIL ADDRESS:** _____
PERSONAL EMAIL ADRESS: _____
RESIDENTIAL ADDRESS: _____
_____ **CODE:** _____
MEDICAL AID: _____ **PLAN:** _____
MEDICAL AID NUMBER: _____ **DEP CODE:** _____
OCCUPATION: _____ **COMPANY NAME:** _____
WORK ADRESS: _____ **CODE:** _____
WORK TEL NO: _____ **GAP COVER: Y / N**
REFERING DOCTOR: _____ **GAP COVER INFO:** _____

PERSON RESPONSIBLE FOR ACCOUNT:

SURNAME: _____ **FULL NAME:** _____
I.D. NO: _____
CELL NUMBER: _____ **HOME NUMBER:** _____
EMAIL ADDRESS: _____ **PERSONAL EMAIL ADRESS:** _____
RESIDENTIAL ADDRESS: _____
_____ **CODE:** _____
MEDICAL AID: _____ **PLAN:** _____
MEDICAL AID NUMBER: _____ **DEP CODE:** _____
OCCUPATION: _____ **COMPANY NAME:** _____
WORK ADRESS: _____ **CODE:** _____
WORK TEL NO: _____
REFERING DOCTOR: _____

NEXT OF KIN:

NAME AND SURNAME: _____
RELATED: _____
CONTACT NUMBER: _____

PLEASE NOTE THAT IF PAYMENT IS NOT MADE WITHIN 60 DAYS, ACCOUNT WILL BE HANDED OVER TO OUR ATTORNEYS FOR COLLECTION. YOU WILL BE LIABLE TO PAY ANY/ ALL COLLECTION AND/OR ATTORNEY CLIENT SCALE FEE.

SIGNATURE: _____ **DATE:** _____

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Notice regarding Professional Fees

This practice values our relationship with our patients and would like to ensure complete transparency on the patient's possible medical healthcare costs associated with this practice. We hereby inform our patients, insurance companies & colleagues that the billing policy of this practice does not necessarily follow the different rates at which the various medical insurance companies reimburse at, or with that of colleagues or any price reference lists.

Competition law requires each medical practice to disclose its billing practice which is determined per the practice's own costing structures and which is also in line with the provisions of the Consumer Protection Act. The tariff charged for healthcare services rendered in our practice is as follows:

- This Practice Charges Above Medical Aid Rates (Private Rates – 217%) and is a Cash Practice.
- First Consultation fees in rooms for 2021 are charged at R1500.00, payable on day of consultation.
- We do **NOT** submit these claims to your medical aid.
- Follow up consultations in rooms will be charged at R900.00, payable on day of consultation.
- We do **NOT** submit these claims to your medical aid.
- In Hospital consultations will be submitted to your medical aid.
- Please take note: The practice will provide (you) the patient with a quotation for the proposed procedure.
- It is the patient's duty to submit the invoice / Quotation to the medical aid. The medical aid will reimburse the patient, and the patient needs to pay the practice directly.
- We do **NOT** submit the procedure claim to the medical aid.
- In or out of hospital procedure claims will not be submitted to your medical aid.

All other Medical aids will be billed at Private Rates (217%)

Because of the varying and different benefits and exclusions on the different medical aid plan options in the market, it remains the patient's responsibility to validate with their medical aid what procedure codes and reimbursement tariffs are applicable on their plan. Even if the patient's medical aid covers a certain procedure, it does not necessarily imply that the medical aid will reimburse all the procedure codes charged by the practice. Please inform the practice if there are any specific pre-conditions which you may have to adhere to on your medical scheme plan e.g. medicine formularies, preferred or designated service providers etc. These aspects can have an influence on the fees you might have to pay, what portion your medical aid will pay and any co-payments that may also be applied.

The medical practitioner and the practice reserve the right to charge for any additional paperwork requested by your medical aid e.g. pre-authorizations, motivation letters, chronic medication forms or reports.

Even if the practice submits the account to a medical aid for re-imbursement, the patient ultimately remains liable for the full costs, the interest as specified in the National Credit Act, and for any costs incurred in the recovery process in the event of the account not being settled in full by the medical aid. Should any of the above be unclear, or should you have any further questions, please do not hesitate to ask the practice staff or doctor.

Name: _____ Surname: _____

Signature: _____ Date: _____

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FINANCIAL POLICY AND YOUR RESPONSIBILITY

Due to increasing problems experiences 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: _____

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SPINAL PROCEDURE QUESTIONAIRE

WEIGHT		KG
HEIGHT		CM
	YES	NO
DO YOU HAVE ANY KNOW BLEEDING DISORDERS?		
DO YOU HAVE HIGH BLOOD PRESSURE?		
ARE YOU TAKING THE FOLLOWING MEDICATION?		
ECOTRIN		
PLAVIX		
WARFARIN		
ARE YOU ON ANY HOMEOPATHIC MEDICATION?		
ARE YOU DIABETIC?		
DO YOU HAVE A HISTORY OF:		
ANGINA		
HEART FAILURE		
HEART ATTACK		
DO YOU HAVE A PACE MAKER?		
DO YOU HAVE HISTORY OF DVT?		
DO YOU SMOKE?		
DO YOU SUFFER FROM ASTHMA?		
DO YOU SUFFER FROM BRONCHITIS?		