LCM SKIN AND LASER CLINIC

PATIENT INFORMATION AND TERMS AND CONDITIONS

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PATIENT INFORMATION:

Full Names and Surname: _____ ID Number: _____

(in the case of a child (person under 18 years of age), please attach a copy of the Identity document or birth certificate)

Home Address: _____

Postal Address: _____

Contact Details: _____ (H) _____ (Cell)
(patient preferred)

_____ (W) _____ (Email)

Referring healthcare practitioner (if applicable): _____

DETAILS OF NEXT OF KIN:

Name: _____ Tel Number: _____

(Please provide us with all possible details as the practice may need to get hold of you urgently in some cases such as when there is important safety information and/or for purposes relating to product recalls)

DETAILS OF PERSON RESPONSIBLE FOR ACCOUNT

Full Names and Surname: _____ ID Number: _____

Home Address: _____

Postal Address: _____

Contact Details: _____ (H) _____ (Cell)

_____ (W) _____ (Email)

Name of Employer: _____

Employers Address: _____

DETAILS FOR DEBT COLLECTING PURPOSES

Information of a family member not living with you, but with whom you are in regular contact:

Name and Surname: _____ Tel Number: _____

Address: _____

I confirm that all information supplied above is accurate and understand that irrespective of belonging to a Medical Aid Scheme I am personally responsible for payment of all fees due to this practice.

SIGNATURE: _____ **DATE:** _____

May we send you news of new equipment, treatment or special offers via:

Email: | YES | NO | SMS: | YES | NO |

TERMS AND CONDITIONS AGREED TO BY PATIENTS / PARENTS AND LEGAL GUARDIANS

***** Please ask us if you do not understand any of the clauses below. *****

PRICING/FEES AND PAYMENT

Fees and payment are set out in our billing policy which will be handed to you and should always be read with these Terms and Conditions.

TIME OF YOUR APPOINTMENT

1. Although we will do our best to render the services at the time we have agreed with you, sometimes a previous patient may require a longer time or an emergency has to get preference. By agreeing to our services, you agree to this uncertainty. We will, if possible, inform you if we run late.

2. If you **cannot keep an appointment** (for any reason apart from an emergency) and you do not let us know at least the day before the appointment (24 Hours), we reserve the right to **charge you the full treatment fee** as we would have lost the opportunity to fill that slot with another patient.

THERAPIST ASSISTANT FOR TREATMENTS (where required)

3. In certain treatments done in this Clinic, an assistant may be present, in the form of an extra Therapist. This person assists in the treatment itself and his/her fees will be included in your account from this Clinic.

CONFIDENTIALITY

4. We will keep all your **information confidential**, including any child over the age of 12.

5. We can only release information with your written consent, even if a family member requests the information. This consent applies to sharing information with your family, medical scheme, insurance company or any other third party.

6. The following special cases exist where because the **law compels us to disclose** your personal information:

   6.1 To your **medical scheme** we must provide a diagnostic code and the details of the treatment and/or operation, so that the scheme can evaluate whether it falls within your benefits. This information is normally provided on your account.

   6.2 To the Compensation Commission (**for work injuries/ diseases**) or the Road Accident Fund (for **motor-vehicle accidents**), if you want to claim from them.

7. We may use your case as an example and may sometimes take pictures or videos to show how treatment was done, as part of research and/or presentations and/or advertising, in the interest of learning and advancing medical knowledge. We will always anonymize your data if we use it.

   Please sign here to consent to this use of information: _____ (initial).

   Otherwise, please delete this section. Please further refer to the **independent treatment information** forms, which you are required to sign before commencing any treatment with this practice.

8. Some medical schemes provide all information on all the family members on a scheme to the principal (main) member. We do not accept liability for any personal information that is disclosed as a result of this.

PURPOSE AND NATURE OF HEALTHCARE

9. You confirm that you understand that in healthcare **results cannot be guaranteed**, as this depends on how one's body reacts to the treatment and/or operations.

10. You confirm that you understand that your own cooperation or that of a child or dependent may affect the outcome of the healthcare and\ or treatment received. You agree to follow the **instructions** provided to you by the Therapists.

    If you don't do this, you undertake to not hold the practice and its staff liable for any negative consequence.

    Initial: _____

EQUIPMENT, DEVICES AND MEDICINES ("GOODS") WE USE

11. In the event that we are required to **substitute** a medicine or device or treatment plan with another one, we will first obtain your consent.

12. Pharmacy- and health legislation prevents us from **taking back any medicines or equipment** this clinic has provided to you. We can also not refund you in these circumstances. This will only apply to medicines and equipment and not to **unopened** cosmetics.

13. If there is a proven quality or performance fault with the goods or treatment, we will contact the supplier, who will deal directly with the matter. They will decide on whether a repair, refund or replacement would be provided. Note that each manufacturer may have its own rules in this regard. In general, if you have made changes to the goods, you may invalidate any warranty.

14. Should you be in treatment/theatre and it is not possible to obtain your consent, as above, we will only substitute medicine or a device where absolutely necessary. Medicine or devices will only be substituted where the original medicine or device is not available or not functional.

CHILDREN AND HEALTHCARE

15. You confirm that you understand that there is a special legal dispensation and forms that must be used in cases of operations on children, even if the Children's Act allows the child to provide consent to treatment without your consent (children 12 to 18 years who understand the implications of the treatment). This practice will provide you with such forms where it is required

AGREEING TO A CONSULTATION, TREATMENT AND/OR PROCEDURE

16. The Consumer Protection Act state that you:

16.1 Have the right to receive accurate information that allows you to make choices based on the options available.

16.2 Must be informed about the purpose of the options (i.e. what it could, or could not achieve and how factors such as one's own body may influence how well the treatment may, or may not work).

16.3 Must be informed about the risk of the options. If the risks are very serious, you should sign a form to say that you know about the possible risks and agree to it – Please refer to the Independent treatment information consent, where applicable.

16.4 Must be informed about the costs of the options.

16.5 Must be issued with instructions on how to use a product / care for yourself before and after a procedure or treatment, etc – Please refer to the pre- and post-treatment instructions.

16.6 Have the right to refuse healthcare, but that the therapist/healthcare practitioner will explain the implications of this refusal to you. If you still refuse you will not be able to hold the therapist/healthcare practitioner liable for any harm you may suffer.

16.7 Confirm that you have been given an opportunity to ask questions surrounding the procedure/treatment and that any questions have been answered in a manner that you understand.

16.8 Understand all risks and benefits of the treatment/procedure.

SPECIFIC TREATMENT

17. You will be required to sign a further form specific to your treatment - Independent treatment information consent - which sets out the details of such treatment and information relating to such treatment.

PATIENT DUTIES

18. You must **adhere to the rules** of the Clinic and **any instructions** given to you by staff or healthcare professionals. You and/or your family or other persons that come to the Clinic should not harass the healthcare professionals, Therapists and staff. They must be treated with respect. If not, we are allowed by law to refuse to treat you or your children. In such cases we will refer you to another practice.

19. You have the **right to ask questions** and to have them answered. If you do not ask any questions, we will assume that you have understood everything and are fine with everything.

Signature: Patient/ Parent/ Guardian **Date** **Signature: Witness**

Confirming that she/he understood and agrees to the above terms and conditions