

PATIENT CONSENT FORM
IN TERMS OF THE PROTECTION OF PERSONAL INFORMATION ACT 4 OF 2013
FOR MEDICAL PRACTICE AND MEDICAL BILLING SOLUTIONS CC

I, the undersigned

NAME & SURNAME: _____

IDENTITY NUMBER: _____

EMAIL: _____

CONTACT NUMBER: _____

Hereby agree to provide my personal information to the medical practitioner/practice, namely: Dr HJ Pretorius Inc. with ID/Reg. No/Medical Practitioner No: 0719900 with the express understanding that:

1. This constitutes my consent, as required under the Protection of Personal Information Act 4 of 2013 ("POPIA").
2. The medical practitioner/practice (and persons associated / employed / affiliated with them) will have access to my personal details, which I have provided, alternatively hereby provides consent for the acquisition thereof to them for the purposes attending to the following:
 - 2.1 the provision of health care services for me and my dependents;
 - 2.2 for the administration of my and my dependents' interactions with my medical practitioner including but not limited to scheduling appointments, referrals to hospital and/or other healthcare professionals, procuring tests and diagnostic procedures, prescribing and dispensing medication, and for the purpose of the processing/payment of accounts, and debt collection;
 - 2.3 for claim submissions to my medical scheme where applicable. In such instance, the information so provided may be provided to contracted operators, specifically Medical Billing Solutions CC ("MBS") and its' employees, subrogates, and assigns. These contracted operators will have access to my personal details, for the purpose of executing their mandate by processing said information, and providing said processed information to Medical Schemes, Medical Insurers, billing houses, and/or other service providers, solely for the purpose of delivering its' services.

- 2.4 for the provision of relevant information to a contracted third party which requires this information in order to provide a healthcare service to me or my dependents;
- 2.5 to share my personal information with external health administrators, managed care providers and other healthcare practitioners for them to assess or evaluate certain clinical information, in the event that I am subject to such a clinical assessment;
- 2.6 to communicate or report to any state regulatory or any other governance body on any matter relating to my personal information that my medical practitioner is by law obliged to communicate and report on.
3. My personal information will only be used for the purposes contained in this form.
4. The medical practitioner/practice, and when applicable contracted operators will in accordance with its POPIA compliance procedures store my personal information as provided for and specified by the relevant legislation from time to time.

SIGNED AT _____ **ON THIS THE** ____ **DAY OF** _____ **20**____

SIGNATURE