ERAD
Leading Radiology

ERADW-07

Patient Information Form

PATIENT DETAILS:

Full Name & Surname: .....

Initials: ..... Title: ..... ☐ Female ☐ Male DOB: ..... / ..... / .....

Email Address: .....

Home Tel: ..... Cell: ..... Relationship to main member: .....

MEDICAL AID DETAILS:

Full Name & Surname: .....

Initials: ..... Title: ..... ☐ Female ☐ Male DOB: ..... / ..... / .....

Home Tel: ..... Cell: .....

Postal Address: .....

Physical Address: .....

EMPLOYER DETAILS:

Company: .....

Tel number: ..... Branch: .....

RELATIVE /FRIEND:

Full Name & Surname: .....

Telephone: ..... Relationship to main member: .....

REFERRING DOCTOR: .....

I confirm that the information supplied is true. I agree that it is the responsibility of the member to obtain pre-authorization should his/her scheme require so. The member will carry the costs / penalties incurred as a result of failed pre-authorization. I further understand that the member is personally responsible for settlement of the account and if applicable, for the submission thereof to the medical aid. Should legal steps be instituted for collection of this, I shall be liable for costs incurred. I hereby give consent that the ICD10 codes of my examination be disclosed to my medical aid in order to qualify for funding. After hour fees might apply that are not covered by Medical Aid. All procedures performed at this facility will be online and available to a restricted community of physicians.

Name (Print): ..... *Signature:* ..... *Date:* .....