ARYA STANA
BONE & BREAST CARE

PATIENT INFORMATION

Title:_____ Surname:_____ First Name: _____

ID: _____

Physical Address: _____

_____ Postal Code:_____

Postal Address:_____

_____ Postal Code:_____

Email Address: _____

Contact Numbers: Work _____

Home _____

Cell _____

Referring Doctor: _____

MEDICAL AID DETAILS

Member's Name: _____

Medical Aid Name: _____

Medical Aid Number: _____

DECLARATION

I _____, being responsible for the above account, understand and accept the following conditions:

1. ARYA STANA BONE & BREAST CARE is contracted out of medical aid.
2. Please be advised that you are requested to settle your account in full, immediately after your consultation and claim back from your medical aid.
3. Please note that your health insurance/medical aid policy is a contract between you and your insurance provider; therefore, we cannot guarantee payment of your claim and must render you, the patient, responsible for any services we offer.
4. Pathology fees relating to a Breast Biopsy or Genetic Testing are separate and directly payable to the Pathologist.
5. You accept that you are fully responsible for payment for services rendered and should you not pay timeously, you will be liable for Debt recovery costs on an attorney and own client scale.

Signed: _____

Date: _____