DR MICHAEL H. NISS
PATIENT REGISTRATION FORM
AND CONSENT FOR TREATMENT

This form explains the general conditions under which this practice sees patients and serves as informed consent.

1. PATIENT DETAILS

Surname: _____

First name(s**):** _____ Initials**:** _____

Residential Address: _____

_____Postal Code: _____

Postal Address: _____ Postal Code: _____

_____

Email address: _____

Telephone: Work: _____ Home:_____

Cell phone: _____ Emergency contact: _____

Date of birth - Year_____Month_____Day____

2. MEDICAL AID DETAILS

Name of Medical Aid: _____

Medical Aid Number:_____

3. PERMISSION TO CONTACT YOU

SMS ☐ EMAIL ☐ VOICE ☐ ANY ☐ NONE ☐

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Melrose North Medical Centre
011 8809072

4. PERMISSION TO CONTACT REFERRING PRACTIONER OR OTHER PARTIES;

In order to communicate about you and your treatment, you have to give your permission. This consent is only valid for the duration of your treatment and may be withdrawn anytime in writing. In addition, you consent to other treating practioners to communicate about your treatment.

ANY INFORMATION DISCLOSED TO THE BELOW MENTIONED PERSON/S WILL BE DISCUSSED WITH YOU BEFOREHAND

PSYCHIATRIST/GP **YES** ☐ **NO** ☐ REFERRED BY: _____

PARENTS: **YES** ☐ **NO** ☐

SPOUSE **YES** ☐ **NO** ☐

5. PAYMENT AGREEMENT

Appointments are payable at time of consultation. It remains your responsibility to submit your claim to the Medical Aid. Fees are above medical aid rates. Psycholegal assessments are 75% above the rate. Appointments not cancelled 24hrs in advance will be charged.

6. PROTECTION OF PRIVATE INFORMATION

Based on your consent provided your personal data will be protected in accordance with your consent and applicable law. (E.g. collection, use, store and share of data).

This practice is obligated to protect personal information of patients, legally and ethically, at all times. I thus understand that no personal information will be disseminated to any third party without my expressed informed consent.

Your contact details are only for the purposes of the practice records unless otherwise stated with your consent. Detailed policy is available on request.

7. ICD- 10 CODES

This practice is obligated to disclose diagnoses to medical schemes with each claim in the form of a diagnosis code. In this regard, I acknowledge and understand that diagnosis code will be provided with my personal details to my medical scheme in order to claim for services rendered.

SIGNATURE: _____ DATE: _____

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