AGREEMENT ENTERED INTO BETWEEN BARBARA PRETORIUS PHYSIOTHERAPIST AND PERSON RESPONSIBLE FOR ACCOUNT

By signing this form, you acknowledge that you have understood and agree to the following:

1. You confirm that all the particulars in the annexed application form: including the information contained herein is true and correct.
2. You agree that you will inform this Practice regarding your changes of personal particulars e.g. address, telephone number, dependents, medication, medical conditions etc.
3. That you have received a copy of the terms and conditions (provided separately) and have had an opportunity to ask questions on aspects thereof that you were not certain about.
4. To abide by the terms and conditions of the practice, in particular the payment of account or if the main member's scheme does not pay in full or pay at all, you will be responsible for the outstanding amount. You acknowledge personal responsibility for this Practice's account.
5. To always ask, even after you have left the practice if you were uncertain about something. If you keep quiet, practice staff and the physiotherapist will assume that you have understood everything and are in agreement with any processes, consents, policies or forms.
6. **If you do not keep your appointment (for any reason whatsoever, apart from emergencies) and you have not let us know at least 24 hours before the appointment, <u>we reserve the right to charge you (not your medical scheme) a portion of the consultation fee as a cancellation fee,</u> as we have kept the slot open for you and could not assist another patient. Your medical aid will not pay this fee.**
7. You consent to the disclosure of your relevant personal information, treatment and diagnostic ICD 10 codes (regarding your physiotherapy treatment) to either your Medical Aid, Account Processing partners and Government Institutions for statistical purposes, as required by law.
8. This Practice cannot guarantee payment or receipt of the account by the Medical Aid or other organizations. You acknowledge personal liability for payment of this account, directly to this Practice notwithstanding any Medical Aid Society or organization or personal undertaking and undertake to ensure full payment of outstanding account within 30 days from the date thereof in the event that the Medical Aid or other organization fails or refuse to pay.
9. You acknowledge that in the case of minors/children, the legal guardian of the child is responsible for the account.
10. In the event that you should fail to pay the outstanding account you specifically.

    10.1 consent to judgement in terms of Section 58 of the Magistrate's Court Act no. 32 of 1944 in favor of this Practice and an order for payment of the balance in instalments equal to 20% of the balance to a minimum of R200 per month (whichever is the least) together with Attorney and Client costs, interest at 2% per month calculated from date of judgement tot date of final payment.

    10.2 agree that a certification signed by this Practice or its Attorney would be sufficient proof of your failure to adhere to the terms of this agreement, and will furthermore be sufficient to prove the outstanding capital, cost and interest due by you.
11. Take note that we are committed to manage your personal information in accordance with the law and have specific processes in place regarding the use and safe keeping of your information.

Signed at Knysna on this _____day of_____20_____

_____ _____

Patient/Guardian Physiotherapist