Smiles4All
DENTAL STUDIO

Dr.F.M.A Pinheiro B.D.S (Wits)
Cnr John Vorster & Logan Ave
Highveld Park Shopping Centre
Tel: 012 665 1631/5
Cell: 071 611 8350
Email: info@smilesforall.co.za

PERSONAL INFORMATION SHEET & AGREEMENT OF PAYMENT

I, the undersigned understand and agree that, in my personal capacity, I stay responsible for the settlement of any costs for the services that I or the patient/my dependent will receive, whether I make provisions towards paying my account in any of the following manners: cash, debit or credit card, EFT or membership of a medical fund/insurance (Cheques are not accepted). The below information is true and correct to the best of my knowledge, and I take full liability and indemnify the practice for all harm/loss /costs incurred by the practice, due to any inaccuracies and/or non-payment/short-payment.

INFORMATION: PATIENT

Title: Choose an Item				Initial	First Name	Surname
Mr.	Mrs.	Miss	Ms			

Identity Number	Cell number:	Email Address:

Relationship to Main Member	Dependent Code	Date of Birth	Age	Sex	
				M	F

INFORMATION: PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT/ MAIN MEMBER

Title: Choose an Item				Initial	First Name	Surname
Mr.	Mrs.	Miss	Ms			

Identity Number	Cell number:	Email Address:

Physical Address		Postal Code	
		Home Tel Number	
Postal Address		Postal Code	
Occupation		Work Tel No	
Home Language:			

Are you under debt review and/or under an existing Administration Order issued by a competent Court for the management of your debts?	Yes	No

MEDICAL SCHEME INFORMATION (PLEASE GIVE YOUR MEDICAL SCHEME CARD AND ID TO THE RECEPTIONIST)

Main Member						
Title: Choose an Item				Initial	First Name	Surname
Mr.	Mrs.	Miss	Ms			

Medical Scheme Name	Benefit Plan/Option Name	Membership number

Smiles4All
DENTAL STUDIO

Dr.F.M.A Pinheiro B.D.S (Wits)
Cnr John Vorster & Logan Ave
Highveld Park Shopping Centre
Tel: 012 665 1631/5
Cell: 071 611 8350
Email: info@smilesforall.co.za

PLEASE READ THE FOLLOWING PARTICULARS CAREFULLY BEFORE COMPLETING THE AGREEMENT OF PAYMENT AND TERMS & CONDITIONS

1. I have acquainted myself with all terms and tariffs applicable and I note that the terms and tariffs for patients covered by medical aid schemes vary. I understand that I must communicate directly with my medical aid scheme for applicable tariffs.
2. This practice is registered with BHF and charges benefit scale fees. If this practice is contracted in with your medical aid, the account will be sent to your medical aid for your convenience and in terms of a special arrangement they will settle the account with us. You will be liable for the account in case of any short payments or non-payments, upon notification thereof.
3. I hereby warrant that (if applicable),
    a. The patient is a bona fide member of the medical aid mentioned herein and his/her membership is valid as at the date of the signature of this agreement; or
    b. I am a bona fide member of the medical aid mentioned herein and my membership is valid as at the date of the signature of this agreement, and the patient is a bona fide dependent in terms of such membership.
4. I choose as *domicilium citandie et executandi* the address detailed on the front page of this application form.
5. Please check your statement of account carefully for any administrative errors and rectify telephonically with the accounts department within 30 days. If the account is not adjusted within 30 days, full payment remains your responsibility.
6. In the event of short payment or non-payment by your medical aid, you will be liable for payment of the outstanding account upon notification thereof by the practice.
7. Appointments must be cancelled 24 hours beforehand.
8. All accounts are payable 30 days after the date of service.
9. In case of bad record of payment, you will be liable to pay cash at the time of service and claim back from your medical aid.
10. All legal and collections costs, including attorneys and client costs and all other costs whatsoever incurred by the practice with regard to recovery of any outstanding amounts pursuant to this agreement will be for the account of the responsible person and will be payable on demand.
11. I confirm that I am an adult (over 18 years)/the parent or legal guardian of child younger than 18 years, and that:
    a. I affixed my signature hereto willingly, without any duress, and with full knowledge of implications of such consent;
    b. I agree to the practice payment policy and these agreement of payment terms and conditions; and
    c. No misrepresentation with regards to the content hereof has been made.
12. I understand that by signing this information sheet form and agreement of payment, I give consent and agree to:
    a. Medical treatment (patient);
    b. Processing of my (and patient's) personal information as set out in the practice Privacy Policy (www.smilesforall.co.za);
    c. Taking responsibility for the payment of the account as set out in the practice payment policy;
    d. My personal information being given to debt collectors and/or attorneys to collect any outstanding debt;
    e. My information being given to medical aid/insurance of which I am a member;
    f. My personal information being given to a dental laboratory to complete any required dental treatment.

_____ _____

Patient/Guardian Signature — Date

Adult (over 18 years)/parent or legal guardian of child younger than 18 years

_____ _____

Person responsible for account/Main Member Signature — Date

Adult (over 18 years)/parent or legal guardian of child younger than 18 years