

LIZANÉ VAN GRAAN

CLINICAL PSYCHOLOGIST

064 285 8179

lvclinicalpsych@gmail.com

REFERRING PRACTITIONER DETAILS			
REFERRING PRACTITIONER NAME:	SCOPE OF PRACTICE:(e.g. Psychologist, GP)	PRACTICE NUMBER:	
1. PATIENT INFORMATION			
SURNAME:	FULL NAMES:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	<input type="checkbox"/> Miss <input type="checkbox"/> Prof. <input type="checkbox"/> Mx.
IDENTIFICATION NUMBER:	BIRTH DATE: / /	GENDER:	
HOME LANGUAGE:	RESIDENTIAL ADDRESS:		
E-MAIL ADDRESS:			
PAYMENT METHOD: CASH: <input type="checkbox"/> MEDICAL AID : <input type="checkbox"/>	IF CLAIM IS TO BE SENT TO THE MEDICAL AID: MEDICAL AID DEPENDENT CODE: _____		
HOME 📞:	WORK 📞:	MOBILE 📞:	
OCCUPATION:	EMPLOYER NAME:		
EMPLOYER CONTACT DETAILS: <i>(We will only contact your employer if we are unable to reach you for account purposes. Healthcare information will only be provided to a specific person nominated by you at your employer, with your written consent.)</i>	📞 _____	✉ _____	
FAMILY / FRIEND CONTACT DETAILS: <i>(for account purposes should we be unable to contact you)</i>	📞 _____	✉ _____	
<p>I hereby accept that –</p> <p>E-mail <input type="checkbox"/> YES <input type="checkbox"/> NO and/or SMS <input type="checkbox"/> YES <input type="checkbox"/> NO and/or Whatsapp <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>messages may be sent to me in order to confirm appointments and convey general information of the practice and my healthcare.</p>			
2. MAIN MEMBER / PERSON RESPONSIBLE FOR ACCOUNT / MEDICAL AID DETAILS (please note that all adults are responsible for their own accounts, even if they are dependents on someone else's scheme)			
SURNAME:	FULL NAMES:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	<input type="checkbox"/> Miss <input type="checkbox"/> Prof. <input type="checkbox"/> Mx.
IDENTIFICATION NUMBER:	BIRTH DATE: / /	GENDER:	
HOME LANGUAGE:	E-MAIL ADDRESS:	2 ND E-MAIL ADDRESS: (if applicable)	

ARMANSIS MEDICAL CENTRE
12 LUDORF STREET
BRITS, 0250



PLEASE TURN OVER

B.A. HONS (PSYCH)(NWU) / B.A. HONS – PRACTICAL PSYCHOMETRY
M.A. CLINICAL PSYCHOLOGY (UL)
CLINICAL PSYCHOLOGIST &
INDEPENDENT PSYCHOMETRIST

PS0133892 PR0724394 PMT0081876 PR0636282

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POSTAL ADDRESS:		RESIDENTIAL ADDRESS: (if different from Postal Address)	
HOME ☎:	WORK ☎:	MOBILE ☎:	
MEDICAL AID:	MEDICAL AID PLAN:	MEDICAL AID #:	
OCCUPATION:	EMPLOYER NAME:		
EMPLOYER CONTACT DETAILS: <i>(We will only contact your employer if we are unable to reach you for account purposes. Healthcare information will only be provided to a specific person nominated by you at your employer, with your written consent.)</i>	☎ _____	✉ _____	

TERMS & CONDITIONS OF THE PRACTICE

I, the undersigned, confirm that:

1. The above information is true to the best of my knowledge
2. That I have the consent of a family member/friend and my employer to disclose their contact details
3. Where I, the patient, am not the Main Member, I have the consent of the Main Member to disclose his/her details for account administration
4. That the patient (dependent) or main member is primarily responsible for payments of accounts for services rendered
5. Medical schemes differ regarding benefits for services rendered, and that it is the responsibility of the patient or main member to contact the medical scheme prior to appointment/admission to confirm any specific stipulations
6. Appointments must be cancelled within 24 hours and failing to do so will result in the full consultation fee being charged
7. The accompanying "**Patient Information Document**" (provided to you separately) has been read and that you as the patient is bound to the content thereof and that you have had an opportunity to ask questions on aspects thereof that you were not certain about
8. You are aware of your rights under the POPI Act, including your right to refuse to consent to marketing and to refuse disclosures - unless required by a law, and to change or remove information, where possible
9. The Account Holder, surety or legal guardian hereby consents to the disclosure and exchange of personal financial information to a credit bureau or financial institution in accordance with the National Credit Act

Information about you cannot be exchanged without your consent. Your signature on this release authorises This Practice to obtain and release personal information regarding your care in accordance with PAIA and POPIA Compliance.
Personal & Special Personal Information is collected, stored & shared by This Practice for the following reasons (for a more comprehensive description of all records held at The Practice as well as policies implemented by The Practice, please contact The Practice Information Officer for a copy of the PAIA Manual as well as the POPIA Compliance Manual.

PURPOSE: For the holistic treatment of you as the patient; For the administration of your patient treatment and the practice; For the performance of duties in terms of any agreement between yourself and the practice; Administrate your accounts and manage any application, agreement, or correspondence that you may have with The Practice; Any other reasonably required purpose relating to The Practice.

I accept this authorization

I do not accept this authorization in the event you choose to keep all information confidential, please note that the payment for all services rendered will be payable on date of service, as the administration process cannot continue)

1. _____ Signature
Patient Name

2. _____ Signature
Person Responsible for Account
(Main member/patient)

Signed at: _____ / _____ /20_____

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