ELZABÉ GROENEWALD
Obstetric Sonographer
PRACTICE NUMBER: 033 0930
cell: 084 577 2705
email: elzabe@fetalview.co.za
ADMIN/BOOKINGS
cell: 082 564 5187
email: admin@fetalview.co.za

I _____ hereby consent to the above mentioned sonography practice collecting, storing, processing and referring to my personal information in accordance with the provisions of Protection of Personal Information Act, 2013 and the Promotion of Access to Information Act, 2000 and furthermore acknowledge and consent to all clauses as indicated in the Patient POPIA Consent Form, of which a copy has been provided to me.

SPECIFIC CONSENT

☐ I hereby confirm that should I bring a third party to my consultation, whether it be my partner/spouse, parent, friend, child, sibling or a third party of any nature; if I should include the third party in the consultation with the sonographer, I hereby consent to my sonographer proceeding to openly discuss results, my condition and any findings relevant to the consultation and to my health and wellbeing, or to that of my unborn baby and all or any other findings relevant to the consultation in such third parties' presence. I acknowledge that it is my responsibility to only bring into the consultation such third party in whose presence such findings can be discussed. I indemnify the practice in this regard and agree to the sharing of my personal and private information relevant to the sonogram results during the consultation.

☐ I hereby consent to the sonography practice referred to above transferring and sharing my personal information with the below mentioned third parties:

- Other sonographers, medical practitioners and affiliated medical and support staff, hospitals, laboratories and companies in so far as it relates to my medical treatment and personal patient care; or is necessary to obtain relevant medical insights into my health and wellbeing and that of my unborn child.
- Third parties, contractors and operators, medical aids, gap cover companies, external service providers and companies in respect of hygiene, laboratory or pathology, hospitals or clinics, IT, software and infrastructure support, billing, legal, nursing, medical assistance and administration and support etc. provided the third party, contractors and operators have incorporated the provisions of the POPI Act to ensure compliance therewith.

☐ I confirm that the personal information I have given to you is true, correct and accurate.

☐ I confirm that I am aware of what personal information pertaining to me is going to being collected, the purpose for which the information is collected and my right to access, object to and update or rectify the information which is collected.

☐ I consent to receive communication with and from the medical practice referred to above via email/ text/telephone call or WhatsApp. I understand the risks associated with the communication via calls/email/whatsapp or text and I release the practice and its employees/directors from any damages that occur as a result of my choice to communicate with the medical practice by call/email/whatsapp or text

☐ I hereby provide consent for the practice and sonographers, staff, officers and other agents to communicate with me at their discretion via telephone/email, WhatsApp and text message on the contact details provided to the practice in respect of any of the above mentioned matters: including:

- Appointment Requests
- Updating of personal information
- Changes to appointments, health insurance information.
- Information about billing and receiving invoices
- Requests or notes/forms for work or insurance companies
- Correspondence regarding test results and screening results and further treatment.
- Any other relevant topic relating to my health care or relationship with the practice.

☐ I hereby consent to the next of kin; whom I nominate on my client information form; being contacted in case of a health care emergency or in respect of arrears accounts.

☐ I acknowledge that I have read and fully understand the terms of consent form and that a copy was made available to me.

☐ I hereby confirm that I am aware of the terms and conditions regarding payment and my obligations in respect of any claim arising by the Practice against me as a patient for services or consultations rendered or to be rendered including but not limited to;

- The Practice charges tariffs with are above medical aid rates.
- All invoices and accounts are due to be settled immediately upon completion of the appointment unless there is a written agreement signed by both parties specifying different settlement terms.
- The practice is not responsible for submitting claims to medical aids, gap covers or any other insurance companies on the patient's behalf.
- Should the practice be required to commence legal proceedings against a patient in respect of monies owed, all legal costs relating to such debt recovery including legal costs, professional services rendered, attorneys fees on attorney and own client scale, collection fees and commission, interest, and tracing costs.

Signed at _____ on the _____ of _____ 20_____

_____

PATIENT SIGNATURE

ELZABÉ GROENEWALD
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Date _____

I _____ hereby consent to the following as an addendum to my original patient consent form:

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Signed at _____ on the _____ of the _____ 20_____

_____

PATIENT SIGNATURE