Diagnostic Radiological Services Inc.
Practice Number: 3800466

TERMS AND CONDITIONS

I, the undersigned hereby declare and warrant that:

- The information provided below is true and correct.

- I undertake to settle the account of Diagnostic Radiological Services Inc. immediately should my Medical Aid refuse to settle my account for whatever reason.

- I agree to pay all and/or any costs, fees and or disbursement incurred by Diagnostic Radiological Services Inc. for the collection of amounts owing by me which may include tracing costs, debt collectors fees and commission as well as attorney fees and disbursements on the scale of attorney and own client.

- I grant consent for any injection and/or other administration of any drugs and/or contrast media which may be deemed necessary for the performance of any medical imaging examination.

- In the event that I am hospitalised, I hereby grant consent for all medical imaging and adminitration of any drugs and contrast media that may be deemed necessary during my stay in hospital.

- I hereby authorise Diagnostic Radiological Services Inc. who are in possession of information concerning my medical diagnosis and treatment, together with my health and personal particulars to disclose such information to my healthcare funder and other healthcare providers. Permission to disclose such information is only for the purpose of treatment and management of my medical condition. I wish to indicate that this consent is given out of my own free will without any undue influence whatsoever.

- By signing this document, I confirm that I am aware that the practice may make the X-rays and other digital images taken by the practice, available in a digital electronic form to medical practitioners, involved in the treatment and management of my medical condition.

- By signing this document, I confirm that I shall be deemed to have read and understood the terms and conditions contained herein and that I am legally bound thereby.

Patient:

Full Name:_____ I.D. Number:_____

Main Member:

Full Name:_____ I.D. Number:_____

Email:_____ Cell Number: _____

Medical Aid Fund:_____ Medical Aid Number:_____

_____   _____
Signature   Date