DR TEMBISA TINI

SPECIALIST OBSTETRICIAN AND GYNAECOLOGIST

MBChB (WSU), FCOG (SA), MMed O+G (UFS)
Practice Number: 0766909

GENERAL TERMS AND CONDITIONS APPLICABLE TO PERSONS JOINING THIS PRACTICE AS PATIENTS

PRIVACY INFORMATION

The personal and health information that is provided by you and recorded in your Electronic Health Record is collected for the purpose of providing you with treatment. All the information provided by you is treated as strictly confidential by Dr Tini and the practice staff. Should you belong to a medical aid and the medical aid forwards such account to the principal member of the medical aid, confidentiality may be compromised as legislation compels this practice to provide certain information to the medical aid on the accounts. Failure to submit the correct codes might lead to claim incorrect being paid or not paid at all.

Regulation 5(f) of the Medical Schemes Act (published in the Government Gazette NO 20566 on October 20th, 1999) states that an account to the medical aid must contain the relevant diagnosis. This must be submitted as an ICD-10 diagnostic code *(number allocated to your diagnosis by international classification of diseases),* and may be used in referral letters, requests for special investigations, prescriptions. During the procedures photos and videos may be taken to be included in your health record as well as for educational purposes. There will be no identifying information attached to the video or photo data that will be published in scientific papers or presented at conferences.

COMMUNICATION FROM THIS PRACTICE

We strive to keep to environmentally conscious initiatives by minimising use of paper. We will e-mail you your accounts, statements, receipts, quotations, authorisation forms. Dr Tini will e-mail you all your results if they are normal. If the result is NOT normal we will call you to schedule an appointment to discuss the results.

PRE-AUTHORIZATION

In the event that hospitalization is required, it remains your responsibility to ensure that the planned treatment is covered by your medical aid and that the necessary finances are arranged to cover for non-insured costs. The medical aids may only cover part of your treatment and you are responsible to cover the gap. The practice will provide you with all the necessary documentation to facilitate authorisation process. Quotations for services are provided for submission with your authorisation documentation, in the case of elective procedure.

Telephone: 041 404 0556 / 041 451 0369 Email: drtini@drtini.co.za Fax: 086 616 9899
Address: Suite 201, Life Mercantile Hospital, Corner Kempston and Durban Roads,
Korsten, Port Elizabeth, 6014

www.drtini.co.za

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SETTLING OF ACCOUNTS

Our fees are based on an independent survey of practice costs within the industry. Dr Tini charges fees similar to other gynaecologists in the area. Fees for consultation and procedures in the rooms are available on request. Office consultations and procedures are due and payable in full on the day of service. Current payment options are credit / debit cards, cash and EFT. Telephonic consultations, repeat prescriptions, authorisations, motivations and medical reports (in the absence of face to face consultation) are billable services. We can provide you with a quotation for any required service.

Your information may be used by Dr Tini to contact you for results of your tests, for medical research to evaluate the service and / or medical treatment that you have received. Please circle YES or NO as appropriate beloW;

Yes	No	I have read the terms and conditions of this practice
Yes	No	I understand that my information will be held by Dr Tini
Yes	No	I am happy for reports on my condition to be sent to health professionals involved in my care
Yes	No	I am happy for my results to be e-mailed to me
Yes	No	I understand that I am expected to acknowledge receiving an e -mail from the practice
Yes	No	I give permission to Dr Tini to seek medical reports about my condition
Yes	No	I consent to my diagnosis ICD-10 code *(number that is given to your condition in accordance with International Statistical Classification of Diseases)* to be provided to the medical aid and main member of my medical aid scheme
Yes	No	I consent to video / photo recording during surgical procedures and for this records to be used for educational purposes with no personal identifying information
Yes	No	I consent to be contacted at a future date for medical research purposes within Dr Tini's practice

I would not like the information to be given to;

1. _____
2. _____
3. _____

Terms of Service

- I agree, that to the best of my knowledge, all the information that I have supplied is true and correct. I have read, understand and accept the content of the general terms and conditions applicable to persons joining this practice as patients, including privacy information, billing information, medical research consent

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- Understand that the practice may charge fees in excess of my medical scheme's rates, dependent on plan, benefits structure and current accepted medical scheme networks as stipulated in the above billing policy.
- Accept that I am fully responsible for payment of services rendered, and that, should I not pay timeously, additional debt recovery and / or legal costs will be generated for which I will be liable.
- Understand that diagnostic and procedural information (as well as any related photographs) related to my treatment may be utilised for practice statistical, research and / or teaching purposes. All such information will be dissociated from patient information and informed consent will be obtained by the practice if any of my information is required for clinical trials or research. I have the right to decline the taking of photography or the use of any images by the practice.
- Health and privacy legislation require that we contractually agree to keep your information confidential. In this document we confirm this undertaking. Certain laws may however compel us to disclose your personal and health information, such as laws that govern motor vehicle accidents, injuries and diseases that occur at your work, or claims to medical schemes. If you do not want us to release information to these entities, please let us know before you leave the practice. In those cases, those entities will then not cover the costs of your care or pay out other claims. You will then have to pay us directly for the services we have rendered. In all other cases we will require your written consent before releasing information to family members, your employer, insurance companies, etc.
- I understand that I am financially responsible for all payments due.

DECLARATION	
SIGNED AT LIFE MERCANTILE HOSPITAL, PORT ELIZABETH, ON THIS_____DAY OF_____20__	
SIGNATURE	

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