

DR MARK STEINMANN

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Practice No: 0383503 • MP 0536296

PLASTIC AND RECONSTRUCTIVE SURGEON

PATIENT DETAILS

(PLEASE PRINT IN BLOCK LETTERS)

Surname..... Title.....
First Names..... Sex.....
Cell..... Tel. (H)..... Tel. (W).....
E-Mail..... I.D. No.....
Occupation..... Date of Birth.....

PERSON RESPONSIBLE FOR ACCOUNT

Surname..... Title.....
First Names..... Sex.....
Cell..... Tel. (H)..... Tel. (W).....
E-Mail..... I.D. No.....
Occupation..... Employer.....
Postal Address..... Work Address.....
Residential Address.....
Medical Aid..... Referring Doctor.....
Plan Type..... Contact.....
Number..... Next of Kin.....
Contact.....

AGREEMENT BETWEEN DOCTOR AND PATIENT/PERSON RESPONSIBLE FOR ACCOUNT

1. I understand that I am fully responsible for the account and I understand that this practice charges private rates and is not contracted to medical aids.
2. First consultations should be paid for immediately by cash or credit card.
3. Interest on overdue accounts is charged in accordance with council rules and I agree to pay all legal fees/collection costs in the event of delayed payment (after 20 business days).
4. I understand that a small percentage of plastic surgical operations require subsequent revision. While a surgical fee may be waived in such case, the patient remains responsible for associated costs such as hospital, theatre, materials and anaesthetist.
5. It is the responsibility of the patient to obtain pre-authorization from their medical aid if required.

Signed:.....

Date:

