Patient

Consent Form

Membership no

Initials Surname

Postal address

Code

Tel no (W) ( ) Cellphone no

Patient's full name

Patient ID no Date of service D D M M Y Y Y Y

Doctor's name Practice no

Patient requested the following out-of-benefit services/upgrades (tariff code, NAPPI code where applicable and costs).
Note: Please add addendum if not enough space.

1. _____

_____

2. _____

_____

3. _____

_____

Patient agreed to the following services not covered (please indicate applicable tariff codes and costs).
Note: Please add addendum if not enough space.

1. _____

_____

2. _____

_____

3. _____

_____

I, the undersigned _____ declare the following:

- That I was informed by my healthcare provider that the medicine/investigation/procedure falls outside my benefits;
- That I am aware that the medicine/investigation/procedure fall outside my benefits and that I am responsible for the payment of these services.

Signed at _____ this day of _____ 202 ____

Signature _____ Witness _____