Patient

Consent Form

gems
Government Employees Medical Scheme

Membership No. Initials

Full Name

Surname

Tel No. (W) Cellphone No.

Postal Address

Code

Patients fullname

Patient ID No. Date of service D D M M Y Y Y Y

Doctors 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.

Sign at this day of 20

Signature _____ Witness _____