

Patient

Consent Form



Membership No.		Initials	
Full Name			
Surname			
Tel No.	(W)	Cellphone No.	
Postal Address			
Code			
Patients fullname			
Patient ID No.		Date of service	
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.

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Patient agreed to the following services not covered (please indicate applicable tariff codes and costs).

Note: Please add addendum if not enough space.

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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