LONGBEACH MEDICAL CENTRE

Practice No: 0191736

DRS G. CLEVELAND, A. RODRIGUES, B. WITNEY, H. HALL & G. JEMMETT

Please complete only **ONE** form per family:

PERSON RESPONSIBLE FOR THE ACCOUNT **Account number:**

Surname:	Initials:	Title:
First name:		ID:
Postal address:		
		Postal Code:
Physical address: (if different)		
Employer:		
Work address:		
Home tel no:		Work tel no:
Cell phone:		Fax no:
Position in firm:		Spouse work tel no:
Email Address:		

MEDICAL AID DETAILS (Please show medical aid cards)

Medical Aid	Option
Main Member:	Number:

FAMILY OR FRIEND (Not from same household)

Name and Surname:	
Address:	
Relationship:	Tel and code:

FAMILY DETAILS

Name	Nick Name	Date of Birth	Dependant number

I the undersigned do hereby:

1) confirm that the above information is true and correct. I undertake to inform you of any changes thereto within 14 days of a change occurring.
2) undertake to forward all statements to my Medical aid and to settle all accounts that have not been paid by the medical aid society within 60 days.
3) TAKE FULL RESPONSIBILITY FOR THE ACCOUNT.
4) accept that as a Private Patient, I am required to settle my account immediately after consult.
5) take of the fact that in the event of non-payment by 90 days my name will be added to the "ITC" list of bad payers.
6) accept and understand that interest will be charged on accounts older than 30 days.
7) accept that in the event of my non-compliance with the above undertaking I will be held liable for payment of all costs incurred in collecting such moneys from me as between attorney and client, including collection commission and tracing costs.

SIGNATURE:	NAME:	DATE:

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