



-N·H·C-

ID NUMBER:

NHC Account Number:

Postal Address:

P. O. Box 2967

Northcliff 2115

Website: www.nhcltd.com

MAIN MEMBER DETAILS (PERSON OR ENTITY RESPONSIBLE FOR PAYMENT OF THE ACCOUNT)

FIRST NAME(S):	SURNAME:	ID TYPE: RSA ID/ PASSPORT/OTHER	ID NUMBER:
GENDER:	TITLE:	INITIALS:	
CELLPHONE:	HOME TEL:	WORK TEL:	
EMAIL:		LANGUAGE:	
MEDICAL AID:	MEDICAL AID OPTION:	MEDICAL AID NUMBER:	
NEXT OF KIN:		NEXT OF KIN TEL NUMBER:	
P.O BOX.	RELATIONSHIP:	STREET ADDRESS	

PATIENT DETAILS (IF PATIENT IS NOT THE MAIN MEMBER):

	1	2	3
DEPENDANT NO:			
NAME(S):			
SURNAME:			
ID NUMBER"			
GENDER:			
TITLE:			
CELLPHONE:			
HOME TEL:			
EMAIL:			

TREATING DOCTOR:

REFERRING DOCTOR:

MEDICAL HISTORY

Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Chronic Medication	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Allergy to local anaesthetic	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Disease/High Cholesterol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Allergy to Iodine	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Allergy to Penicillin	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Parent/guardian
to initial:

Patient to initial:

Main member to
initial:



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TERMS AND CONDITIONS

- 1. "Inc/s" means the personal liability company/ies to whom the Medical Practitioners are contracted to render services at the NHC.
- 2. "Medical Practitioners" means the persons who render the medical services to the Patient at the NHC.
- 3. "NHC" means the NHC Medical and Dental Centre.
- 4. "Nimpa" means Nimpa Limited a public company with registration number 1993/004361/06.
- 5. "Patient" means the person who receives medical services at the NHC.
- 6. "Signatory" means the person who signs this form.
- 7. "Treatment" means the medical and/or health related treatment received by the Patient at the NHC including all incidental services related to the treatment received.
- 8. Nimpa Ltd is the owner of the NHC and:
 - 8.1. Is only responsible for the administration of the Inc/s and the NHC and the collection of payment of all amounts owed by patients in terms of the Treatment received by them;
 - 8.2. Has no control whatsoever over the acts, omissions and/or activities of the Medical Practitioners or the Inc/s and may not be held liable for any acts or omissions of the Medical Practitioners or the Inc/s.
- 9. The Medical Practitioners at the NHC:
 - 9.1. Are not employees, agents, or representatives of Nimpa or the NHC; and
 - 9.2. Render their services to the Patients as independent practitioners who are contracted to the Inc/s.

The Patient and the Signatory understand that Nimpa and/or the Medical Practitioner, in its/their sole discretion, may refuse Treatment to the Patient, in the event that the Patient and/or Signatory elect not to sign these Terms and Conditions.

PAYMENT TERMS AND INVOICING

- 10. Nimpa shall submit an invoice to the Signatory, on behalf of the Inc., for payment in respect of the Treatment received by the Patient;
- 11. All invoices shall be payable by the Signatory on receipt;
- 12. Nimpa however, reserves the right to require payment in advance of all or part of any amount/s which may become payable in respect of the Treatment of the Patient;
- 13. The Signatory undertakes personal liability for payment of all amounts payable to the Inc. in respect of and incidental to the Treatment of the Patient, notwithstanding the fact that the Patient may be a member of, or a dependant under a medical aid/medical benefit scheme;
- 14. The amounts payable to the Inc. in respect of and incidental to the Treatment of the Patient shall be calculated on the basis of the fees, rates and charges imposed by the applicable Medical Practitioner on the date of the Treatment;
- 15. In the event of any amount owed to the Inc. not being paid on the due date, the Inc. shall be entitled, in its sole discretion, to claim interest on the outstanding amount owed to it, at a rate of 2% (two percent) per month;
- 16. The Signatory further undertakes that he/she shall be liable for all legal costs incurred by Nimpa and/or the Inc. in recovering any outstanding amounts owed to it in respect of the Treatment of the Patient, which costs shall be calculated on the attorney client scale and shall include collection commission;
- 17. All amounts payable to the Inc. exclude VAT.

INDEMNITY

- 18. The Patient and Signatory hereby indemnify Nimpa and the Inc. and their employees and agents against and hold them harmless in respect of:
 - 18.1. Any claim, award, judgment, costs and expenses which may be made, awarded, or suffered by Nimpa or the Inc. resulting from the Treatment of the Patient at the NHC, whether directly, or indirectly;
 - 18.2. Any claim, damages, actions and/or liabilities and costs including without limitation direct, indirect, incidental, special, consequential or punitive damages/loss incurred by the Patient (or his/her heirs and dependents) as a result of the Patient's attendance at the NHC and/or his/her Treatment;
 - 18.3. The loss of, or damage to any of the Patient's possessions (including money and other valuables), which were not handed in at the reception of the NHC for safe keeping, in which event an official receipt would have been issued by Nimpa.

- 19. The Patient and Signatory expressly absolve Nimpa and the Inc., together with their agents and employees from all liability for any loss and/or damage of whatever nature, whether arising in delict or for breach of contract, including but not limited to consequential loss or damage, arising directly or indirectly out of any act or omission and/or breach and/or injury (including death) sustained by and or harm caused to the Patient or any disease contracted by the Patient (including terminal disease) whatever the cause may be, whilst receiving Treatment.
- 20. The indemnities contained above shall not apply if the claim, award, judgment, costs, expenses, damages, actions, liabilities, death and/or disease were caused by the gross negligence of Nimpa or the Inc., or either of their agents and/or employees.

PERSONAL INFORMATION

- 21. The Inc. and Nimpa shall obtain personal information and special personal information (as defined in the Protection of Personal Information Act, 2013 "POPIA") regarding the Patient and personal information regarding the Signatory (collectively referred to as "the Information").
- 22. The processing of the Information in respect of the Patient and their Treatment and in respect of the Signatory, is necessary for the proper treatment and care of the Patient and/or for the administration of the Inc.
- 23. The Patient and the Signatory consent to Nimpa and/or the Inc. processing their Information (including the special personal information of the Patient) for the purposes of, through the Medical Practitioners, providing the Patient with Treatment and for directly related purposes, including:
 - 23.1. Communicating with the Signatory and/or the Patient regarding the Treatment and related matters;
 - 23.2. Disclosing such Information, including the ICD-10 coding, as is required by the Patient's medical aid provider and/or the Compensation Commissioner or insurer (or to any of their agents), to whom a claim is submitted, in relation to the amounts payable in relation to the Treatment received by the Patient;
 - 23.3. Contacting the account holder/main member of the medical aid scheme of which the Patient is a member, and disclosing the information to the aforesaid person, to the extent reasonably required in order to enable Nimpa (or its duly authorised agent) to obtain payment of the invoice in relation to the Treatment rendered to the Patient;
 - 23.4. Notifying the Patient via a text message sent to his/her cellphone number, when such Patient checks in at the NHC;
 - 23.5. Maintaining medical records as required in terms of Nimpa's and/or the Inc.'s internal policies and by law; and
 - 23.6. For any other purposes required or permitted by law.
- 24. The Patient and Signatory understand that Nimpa and the Inc. may outsource some of its/their services, which may involve Nimpa and/or the Inc. sharing the Patient and/or Signatory's Information between each other, as well as with third parties in order to enable the required services to be rendered to the Patient. Nimpa and/or the Inc. shall ensure that all such third parties agree to be bound by the provisions of POPIA in relation to their processing of the Information to the extent applicable.
- 25. Although Nimpa and/or the Inc. will usually collect the Information directly from the Patient and/or the Signatory, Nimpa and/or the Inc. may need to collect the aforesaid Information from a third party (for example, a relative or another health service provider) in instances where such collection would not prejudice the legitimate interests of the Signatory or Patient, or where such collection of the Information is necessary to maintain the legitimate interests of the Inc. or Nimpa.
- 26. The Patient and Signatory consent to the Information being disclosed to the other Nimpa facilities and their Medical Practitioners in order to efficiently coordinate the Patient's Treatment.
- 27. Should the Patient and/or Signatory refuse to provide any of the Information required by the Inc. or Nimpa, the Inc. may be unable to proceed with the Treatment of the Patient.

Do you consent to Nimpa and the Inc. using your email address/cell/telephone number for the purposes of sending you communications pertaining to your health and wellbeing and our services and related information?

PATIENT: YES: ___ NO: ___

SIGNATORY: YES: ___ NO: ___

Signed by the MAIN MEMBER at: _____ on the _____ day of _____ 20____

Full name/s & surname Signature

Signed by the PATIENT (to the extent that he/she is not also the main member) at: _____ on the _____ day of _____ 20____

Full name/s & surname Signature

Signed by the PARENT/LEGAL GUARDIAN of the patient who is under the age of 18 at: _____ on the _____ day of _____ 20____

Full name/s & surname Signature