Dr Wewege and Associates Inc

t/a Copperfield Child Care

Practice number: 0724858 Dr A. Wewege, Dr H. van der Watt, Dr L. Smith, Dr J. Buckley

The principal member is responsible for all accounts. We will deliver the invoice to your medical aid where possible but payment of the account remains the responsibility of the patient or guardian or main member as detailed below. **Immediate payment is required for all PRIVATE patients.**

PATIENT INFORMATION FORM

PATIENT DETAILS

Surname:			Sex:
Childs Name:			D.O.B
Has your child seen this practice before?	**Y**	**N**	ID Number (if applicable):

MAIN MEMBER DETAILS	**SECOND PARENT DETAILS**
Full Name:	Full Name:
ID Number:	ID Number:
Occupation:	Occupation:
Marital Status:	Marital Status:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email Address:	Email Address:
Home address:	Postal address: (if different)

MEDICAL DETAILS

Full Name:	Medical Aid:		
Membership #:	Option/Plan:		
Dependant code:	Referring Doctor:		
Family Doctor Name:	Gap Cover:	**Y**	**N**
Contact number:	Name of institution:		

I confirm that the information provided by me is true and correct

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Signature Date:

SIGNED BY PARENT/GUARDIAN OR PERSON RESPONSABILE FOR THE ACCOUNT

PLEASE TURN OVER

Dr Wewege and Associates Inc

t/a Copperfield Child Care

I, the undersigned, am personally responsible for payment and not my medical aid. In the event of divorce the parent accompanying the minor is responsible for settlement of the account. In the event of any legal action being instituted against me for recovery of any amount whatsoever, I shall be liable for all legal costs including admin costs and a 20% admin fee on each instalment paid. If the matter is defended, I will be liable for legal costs incurred on an attorney/client scale. Once my account has been handed over there will be no further correspondence entered into with the practice. All correspondence will be with AxialCollect. The National Credit Act 34 of 2005 is not applicable to this claim.

I hereby choose my above address as my domicilium citandi et executandi for all purposes under this agreement.

I HAVE READ, UNDERSTAND AND AGREE TO THE CONDITIONS MENTIONED ABOVE.

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Signature Date:

AxialMed agrees to maintain the confidentiality of your confidential information that the patient grants AxialMed access to and undertakes to utilise the said confidential information for the purpose of rendering of accounts.

Serviced by

AXIALMED
Practice & Business Specialists

Working Hours: 8:00 am – 4:15 pm
Telephone: 021 406 9911
Email: accounts@axialmed.co.za
www.axialmed.co.za