DENTAL SURGEON

Dr. Ronel Podde

BChD (Pret); PDD (Implant)(UWC)

Pr Nr: 0335967

E-MAIL: accounts@drgreenapple.co.za	**UNIT 16A, KRUIN BUSINESS CENTRE,**	**P.O. BOX 1533**
TEL: (012) 543-2897	**406 BRAAM PRETORIUS STREET,**	**MONTANAPARK**
FAX: 086 599 4011	**MAGALIESKRUIN, 0186**	**0159**

E-MAIL: accountsw@drgreenapple.co.za	**UNIT 6, WATERKLOOF FORUM,**	**P.O. BOX 1533**
TEL: (012) 460-5064	**374 MILNER STREET,**	**MONTANA PARK**
FAX: 086 599 4011	**WATERKLOOF, 0181**	**0159**

DR. RONEL PODDE INCORPORATED INFORMED CONSENT

I, the undersigned irrevocably declare and undertake as follow:

- That I have been fully informed that Dr Ronel Podde Inc. charge Medical Aid based benefits on Basic Dentistry and Medical Aid based benefits plus a 15% co-payment on Specialized Dentistry.
- That I am aware that Dr Ronel Podde Inc. 15% co-payment on Specialized Dentistry and any other dental code not accepted/recognized by my Medical Insurer are to be settled before or directly after each visit.
- That I am aware that Dr Ronel Podde Inc. will submit Medical Aid benefits charge to my medical aid as provided and checked by me with every appointment. That it is my responsibility to inform Dr Ronel Podde Inc. of any changes in the information given regarding my Medical Aid. That Dr Ronel Podde Inc. will not be held responsible if claims are submitted to wrongful information given or not given by myself.
- That I accept full responsibility for any dental claim that is not paid out to Dr Ronel Podde Inc. by my Medical insurer within 30 days from the date of treatment.
- That I am aware that Dr Ronel Podde Inc. fees are based on the cost study preformed by SADA and submitted to the Department of Health in 2009, the 2006 HPCSA fees, adjusted against inflation and the South African Dental Association D-Calc cost calculator. The Competition Commission declared Medical Price Fixing, by Medical Aids or Doctors, as illegal.
- That it is my obligation to request a full written cost estimate before commencement of my treatment;
- That no estimation will be given without x-rays and/or digital photo's being taken of the patient.
- That I must personally consult with my medical insurer on their portion of payment on my cost estimate;
- That I accept full responsibility for any portion of payment or dental code not accepted by my Medical insurer before or directly after each visit.
- In the event that this account is handed over for collection I consent to legal fees on an attorney and client scale, collection commission, tracing fees and VAT (if applicable). Interest of 9% per annum will also be payable to Dr Ronel Podde Inc. Thirty-day accounts will be handed over for collection;
- That I have the right to contact Dr Ronel Podde immediately if any dispute or complaint arises. In the event that a satisfactory solution cannot be reached, the service of Dental Ombudsman is available. dentalmediator@sasa.co.za Tel: (011) 484-5288
- That it is my responsibility to obtain authorization from my Medical Aid for work to be done as well as hospitalization if necessary. Even if Dr Ronel Podde Inc. assist with authorizations, it still is my responsibility to verify if such information given is correct and that Dr Ronel Podde Inc. cannot be responsible for incorrect or the lack of information provided by my Medical insurer. That I accept full responsibility for short-payments by my medical aid.
- That an additional after-hour fee will be charged outside normal working hours;

- That in the event of a contractual dispute or any cause of action, ligation shall only be instituted in a court of the Republic of South Africa;
- That I selected the address below as my Domicilium Citandi et Executandi for all purposes under the agreement.
- That any registered notice which is forwarded to this address will be deemed to have been received three days after date of posting. I undertake to inform Dr Ronel Podde Inc. in writing by means of registered post one week in advanced should this address change;
- That I consent to the taking of photographs and/or x-rays which might be used for teaching and informative purposes;
- That I accept one of the following payment methods for co-payments and shortfall payments by my medical aid: Credit Card, Debit Card, EFT (to be made before or IN the practice).
- I give consent that Dr Podde's practice may contact me via sms or e-mail regarding the confirmation of my appointments, recalls and inform me of practice news and relevant accounts.
- That I accept that a fee of R500 per hour will be charged automatically for all appointments not kept and not cancelled 24hours prior to my appointment. Appointment longer that 1-hour must by cancelled 48hours prior to the appointment to avoid the fee as per above.

Signed by me on the _______day of____________________, 20________

Full Names: ____

ID No: ____

Physical Address: ____

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____

Postal Address: ____

____

____

E-mail: ____

Signature: ____

DR. RONEL PODDE INC.
www.drgreenapple.co.za.