DR BASSON
SPECIALIST SURGEON

PAYMENT POLICY

Each medical aid or insurance fund decides on its own level of reimbursement. Some pay our fees, and some do not pay the full fee. We provide a quotation and an estimate of the cost before you agree to any treatment. This does not apply during weekends or after-hours hospitalisation as our administration is closed and emergency rates apply.

Consultation fees in the practise must be settled immediately after consultation and then claimed by yourself from your medical aid. **We are a cashless practice and do not accept cheques**. All major credit cards are accepted. Please make timeous arrangement with your doctor if you have absolutely no other option. We appreciate your understanding in this matter.

Fees for all procedures including operations and endoscopic procedures, such as gastroscopies and colonoscopies and that are settled immediately may qualify for a **10% discount**. Unless privately funded, your account is submitted to your medical aid by us. You will receive a confirmation of this from your medical aid.

Certain procedures are paid out of your medical aid's savings account. Please ensure that you have enough available funds. Please contact us if you do not promptly receive an account from our practice as late submission to your medical aid may result in your claim being rejected.

Any discounts given also lapse if the account is not timeously paid to us. Payment of your account within 30 days of receipt remains your responsibility unless other written arrangements have been made and approved with our accounts department. Interest at prime **+2% accrues after 60 days**. Overdue accounts are handed over to a debt collection agent.

Where necessary, you will be assisted with all the required documentation and the procedures for obtaining authorisation from your medical aid and you will receive a detailed statement of your account. Feel free to contact our accounts department for any enquiries or queries. accounts@drgbasson.co.za Reynette Naude Ph: 012-012 9069

Please note that your anaesthetist fee is separate from your hospital and surgeon's account. For more information on the anaesthetist's account please contact:

Anaesthetist	Company Account	Contact	Email
Dr M Snyman	MAC	Lené 012-333 5584	lene.mac01@gmail.com
Dr I Schreuder	Spescred	Bridget Briel 012-012 6098	drschreuder@spescred.co.za
Dr I Noeth	MBSCC	Rina Kretzman 012-662 0505	rina@mbscc.co.za

We thank you for using us as your health care practitioners.

Patient Initial: .....

Address: Suite 206, Mediclinic Midstream, Midstream Drive, Hill Boulevard, Midstream Estate, 1692
Reception: +27 (0) 12 652 9491 / 9496
Accounts: +27 (0) 12 012 5202
e-mail: midstream@drgbasson.co.za
website: www.drgbasson.co.za
Practice number: 042 000 0398772

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PAYMENT TERMS AND CONDITIONS

Liability for payment:

I, the undersigned, do hereby:

- acknowledge that I have been informed that this practice does not charge the rates that the Department of Health has unilaterally determined for doctors, and which are known as the Reference Price List (RPL);
- confirm that I am aware that this practice fees are charged up to 3 times the RPL;
- confirm that I am aware that the RPL values for services are available from the Department of Health (Tel: 012-3120000) and the Health Professions Council of South Africa (Tel: 012-3389300 / www.doh.gov.za)
- accept that although I am a member of a medical scheme, I remain fully responsible for payment of the doctor's account until paid in full. These terms and conditions are entered into with the patient and not the medical scheme/aid.
- acknowledge that the fees charged by the practice may be different to the benefit to be paid by my medical aid/scheme, and I accept responsibility for any co-payment resulting from the difference between these two amounts.
- the fact that the practice may submit a claim to the medical aid/scheme, Compensation Commissioner, Road Accident Fund, or an insurer, will not in any way relieve me of my liabilities as aforesaid.
- confirm that, should I not pay timeously, I will be liable for payment of legal fees incurred by the practice in recovering any amount due (including but not limited to tracking costs and collection fees) on attorney and own client scale.
- acknowledge that the doctor reserves the right to charge for all follow-up consultations, irrespective of whether it is in the rooms, the ward, high care, or the intensive care unit.

Medical Scheme Benefit

- I warrant that, as indicated, the patient is a current, paid-up member or dependent of such member under the medical aid/scheme, and that the patient has not resigned, or services have not been terminated.
- I authorise the practice to submit the account to the relevant medical aid/scheme for payment on behalf of the patient.
- I give permission for the use of ICD-10 codes for more effective account payment by the medical scheme.
- I undertake to:
    - ensure that accounts are received by the medical aid / scheme and paid within 90 days of service. I acknowledge that an account older than 3 months will not be settled by the medical scheme and I will be held responsible for the settlement of the account.
    - settle the account within 30 days in case of non-payment or short payment of the medical aid / scheme and acknowledge liability for interest charged on payments made later than 30 days.
    - I acknowledge the pre-authorization for treatment / services do not guarantee payment by the medical aid / scheme, and that it remains my responsibility to obtain such authorisation if required by my medical aid / scheme.

Disclosure of medical information:

- The practice is hereby authorized to disclose to the medical aid/scheme, or the Compensation Commission or the Road Accident Fund or insurer to whom a claim has been submitted, in relation to amounts payable to the practice, full details as to the nature, diagnosis, condition, or treatment of the patient.
- The responsible person and/or patient has been informed that in certain circumstances, such as disclosure of ICD-10 codes, the exact consequences of disclosing such information are unknown to the practice and that information relating to these consequences, must be obtained by a responsible person and/or patient from the third party to whom the information is disclosed.

General:

- I/We the undersigned, hereby confirm that the practice may use the email addresses as indicated in the patient/guarantor details for communication purposes on accounts and/or invoices.
- I undertake to notify the practice of any changes in my indicated address, contact details or medical aid details.

Signed at _____on the _____2025.

_____	_____	_____
PATIENT NAME	PATIENT SIGNATURE	WITNESS SIGNATURE