

GAP COVER DETAILS

Name of Gap: _____

Contact number: _____

PAYMENT OF ACCOUNTS

This practice is **NOT** contracted to any medical aid. Accounts will be charged at **300%**. Accounts will, however be submitted directly to the Medical aid on your behalf, for procedures and in hospital visit only on the understanding that should your medical aid not accept the whole or part of the account you are personally liable for any unpaid amounts,(Hospitalisation/operation accounts ONLY.)

1. I agree to pay the Specialist Surgeon's fee; I understand that the doctor may offer a discount for early settlement i.e. 30 days from date of service.
2. The fee is due and payable immediately on completion of the service. The account will be rendered to the relevant medical aid.
3. I understand that i will remain personally responsible for payment of the account as per this agreement. I understand that i have a separate agreement with my medical aid which may not fully reimburse me, and all outstanding accounts will be payable by myself.
4. I agree to handover any monies paid by my medical aid to my personal bank account for doctor's services rendered immediately.
5. I agree that interest will be charged on all outstanding amounts on a monthly basis.
6. I also undertake to pay all legal, debt collection and tracing costs on the attorney and own client scale and charges as stipulated by the Debt Collectors Act of 1998 relating to the recovery of fees on my account in respect of doctor's and other professional services rendered.
7. I consent to sharing information on my account with other credit grantors and with the credit bureau.

I have read and understand the contents above. I confirm that the particulars furnished by me are in all respects true and complete.

Please note Dr N Govender charges 300% of medical aid rates.

Patient name

Signature

Date