DR MELANÉ VAN ZYL

PSYCHIATRIST

MBChB (UFS) MMed Psych (Stell) FC Psych (SA)
Pr Nr: 021 3349

Medi Village, Unit 12, Cnr Joubert & Grey Avenue, Vereeniging 1939
Mediclinic Emfuleni, Second floor, room 206, 6 Jan van Riebeeck Boulevard, Vanderbijlpark 1911

Tel: 016 004 0166
Fax: 086 577 0833
info@thejoylab.co.za

All fields marked with * are mandatory

	PATIENT	MAIN MEMBER (if different from patient)
PERSONAL DETAILS		
Full name*		
Surname*		
ID number*		
Date of birth*		
Title*		
Home language		
Marital status		
CONTACT DETAILS		
Home		
Work		
Cell phone*		
Cell phone nr for appointment reminders*		
E-mail *		
Employer		
Physical / Postal* address	Code:	Code:
Referring Doctor		Referral letter Y N
MEDICAL AID DETAILS		
Medical Scheme*		Option / plan*
Membership number*		Dependant code*
Relationship to main member*		
NEXT OF KIN		
Full name & surname*		
Relationship to patient*		Cell phone*

*I (name & surname),______________________________________hereby confirm that the above information is correct.

By signing this I declare that I have read the Practice's terms and conditions (dated 01/01/2022) and that I have understood the information therein. I also agree to receive emails and SMS's from this practice.

____________________	__________	____________________
Signature: patient/parent/guardian	**Date**	**Signature: Witness**

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PATIENT CONSENT FORM

PRIVACY OF INFORMATION AND PROTECTION OF PERSONAL INFORMATION

Patient and Legal Guardian

I, ____,(full names of patient)

AND

in the event of a legal minor under the age of 18:

____(full names of Legal Guardian) as (state relationship to the patient eg, parent etc) ____.

having

ID Number of Patient (if 16 years of age or older):____

ID Number of Legal Guardian (if patient is legal minor):____

do hereby confirm that:

Consent to Treatment: Your right to privacy and confidentiality is protected by South African Legislation including the South Africa Constitution, the National Health Act, the Mental Healthcare Act and The Protection of Personal Information Act (POPIA). You are therefore requested to provide this practice/clinic/hospital with consent to treatment and consent to disclosure of information. Said information shall be utilized to serve as motivation for payment by medical schemes and shall be utilized to monitor your progress and care**. Please read through below and complete.**

1. I am twelve (12) years old or older, and of sound mind and sufficiently mature to provide voluntary consent to treatment.
2. I hereby provide my voluntary consent to treatment by the duly qualified and authorized doctor and/or staff of Dr Melané van Zyl and understand that such treatment may have risks.
3. I understand that I may withdraw my consent, which is my right, at any time of my choosing, and will inform this practice/clinic/hospital of such withdrawal of consent immediately. Without derogation of the practice/clinic/hospital's record keeping obligations under law, I may obtain a copy of my records taken by the respective health practitioner, or in the event of furtherance of my medical interests, such as consultation with another health practitioner, the original record taken by the health practitioner.
4. I voluntarily consent to provide personal information to the practice/clinic/hospital including my name, ID number, exact physical address, contact information(email and telephone, sexual orientation, ethnic or social orientation, age, religion, well-being, physical and mental health, culture, financial information and medical aid information; all the aforementioned relating to myself as an identifiable living natural person ("**Personal Information"),** provided that the practice/clinic/hospital; treats this Personal Information as confidential and that the practice not pass on this Personal Information to third parties except as necessary for medical scheme claim purposes as per paragraph 6 and as per paragraph 9,10 below .
5. I voluntarily consent to the practice/clinic/hospital disclosing information regarding my medical history, medical condition, suburb/town/city of residence or employ, diagnosis, prognosis, treatment, improvement in diagnosis and recovery, including ICD 10 Codes ("**the Medical Information**"), to my medical aid, and I understand that such disclosure to my medical aid may result in a breach of my confidential Personal Information. I further understand that my Personal Information as it relates to my health may be processed by medical professionals, health care institutions or facilities or social services which is necessary for my proper treatment and care and or for the administration of the institution and or medical practice in accordance with section 32 of POPIA.
6. I understand and consent to my Personal Information and Medical Information in paragraph 4 and 5 being captured electronically onto OutcomesIT patient record management database belonging to Outcomes IT (Pty) Ltd, which database being hosted on a server in South Africa, and that the practice/clinic/hospital has satisfied itself that all reasonable measures have been taken by OutcomesIT to ensure that such electronically captured Personal Information and Medical Information remains secure and confidential at all times.
7. I shall provide a full medical history to the clinic/practice/hospital including all medical conditions which I have or have had, and any medicine that I have or am taking.
8. I voluntarily provide my consent to the practice/clinic/hospital to arrange for, and or provide, as necessary, emergency medical treatment in the event it is required or deemed to be required.
9. I voluntarily consent that the practice/clinic/hospital may provide the Medical Information to other registered healthcare practitioners as registered under the Health Professions Act No. 56 of 1974 (as amended) for referral reasons and or social workers as registered under the Social Service Professions Act and or nurses as registered under the Nursing Act No 33 of 2005; all of whom shall be involved in the management of my health and medical care.

10. I voluntarily consent to my Medical Information being used for research/study/statistical analyses/funding motivation purposes and may be passed on to third parties as de-identifiable data or anonymized data ("**Anonymized Information"**). (i.e. **no** personal identifiable information including name, ID number, exact address, telephone number, email and other contact details will be passed on to any third parties for any reason whatsoever.)
11. I understand that in the event that the practice is accredited with the Health Professions Council of South Africa (HPCSA) as a training facility for students and I consent to treatment by such students or interns.
12. I understand that this consent is subject to the Health Professions Act No. 56 of 1974 (as amended), the Health Professions Council of South Africa (HPCSA), the Mental Healthcare Act, the Social Service Professions Act, the Nursing Act, the Protection of Personal Information Act No. 4 of 2013, the Electronic Communications & Transactions Act no. 25 of 2002, the Children's Act No. 38 of 2005, the National Credit Act No. 34 of 2005 and that the provisions of legislation will prevail in the case of any conflict with this document.
13. This form shall not in any way be interpreted as derogating from any power or authority or right vested in law to another person, court or statutory body requesting access to such information.
14. **I acknowledge that my rights have been explained to me, that I have had an opportunity to discuss the content hereof and ask questions relating to the content hereof, and that I am satisfied to continue, and I provide my consent voluntarily, freely and without duress or undue influence. Where I am a minor, my legal guardian listed hereunder has had an opportunity to discuss the content hereof and ask questions relating to the content hereof, and is satisfied to continue, and provides voluntary consent freely and without duress or undue influence.**

SIGNED at (place) __________________________________ this ___________ day of (month, year)____________

____

Signature of Patient (12 years and older)

Full Names of Patient:____

____

Signature of Legal Guardian

Full Names of Legal Guardian if patient is younger than 18 years:____