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DR STEFAN VISAGIE INC

SPECIALIST SURGEON

MBChB (Pret) - FCS (SA) - MMed (Chir)(Stell)

PR 1252593 | MP0636134
Dr Stefan Visagie Specialist Surgeon:
2025/106080/21

REGISTRATION FORM (please print in block letters)

PATIENT DETAILS:

Surname: _____ First Names: _____

ID No: _____ Occupation: _____

Postal Address: _____

_____ Code: _____

Residential Address: _____

_____ Code: _____

Tel No: (H) ____ _____ (W) ____ _____ (C) _____

email: _____ Referring Dr: _____

MEDICAL AID DETAILS:

Name of Medical Aid: _____ Plan: _____

Medical Aid No: _____ Name of Main Member: _____

Main Member ID: _____

Postal Address:: _____

_____ Code: _____

Tel No: (H) ____ _____ (W) ____ _____ (C) _____

Employer: _____

AGREEMENT: I hereby accept full responsibility for payment of all outstanding amounts due to Dr SJ Visagie for services rendered to me or my family. **In the event of my medical aid rejecting claims forwarded to them I further accept full liability for the outstanding balance of such amounts.** Terms are 30 days treated as cash and interest at the mandatory rate on all overdue accounts. Each and every account serves as a final notice and failing payment appropriate steps will be taken to recover unpaid overdue accounts. I understand that I will also be liable to pay collection commission, legal costs and all other costs of collection agents, should we have to resort to such means to claim overdue amounts from me.

I UNDERTAKE TO ADVISE YOUR PRACTICE OF ANY CHANGE OF ADDRESS OR DETAILS PROVIDED.

PLEASE NOTE:

Any claims not settled by medical aid in three months become the responsibility of patient to settle.

_____ _____

Signature of patient / parent / guardian Date