Chest & Allergy Centre
Specialist Paediatric Care

Dr Sarah Karabus
Paediatric Allergist and Paediatrician
MBChB (UCT), FCPaed (UCT), MRCPCH (UK), DCH (SA), FAAAAI (USA), Diploma of Allergology
Practice no: 0304565

This practice charges the fees that are commensurate with the level of services, the experience and expertise of the practitioners who render services. The fee depends on the duration of the consultation, is inclusive of VAT and may change annually. Please ask the receptionist about our current fee structure. Parents are jointly and individually liable for the healthcare of their children. **Irrespective of on whose medical scheme the child is a beneficiary, the parent who brought the child for healthcare will be liable for the account should the medical scheme not reimburse the account.** Immediate payment of account balance after medical aid submission is required after the consultation.

PATIENT DETAILS	FIRST PARENT DETAILS (preferred contact)
Surname:	Full Names:
Full Names:	RSA ID or Birth Date:
Nickname/Known As:	Home Address:
Sex *(please circle)*: Male Female	
RSA ID or Birth Date:	Post Code:
With whom does child live? *(please circle)*	Postal Address:
Both Parents Parent 1 Parent 2	Post Code:
Other, please specify:	Home Phone:
REFERRING DOCTOR	Cell Phone:
Name:	Email:
Telephone:	Work Phone:
Email:	Occupation:
MEDICAL AID DETAILS	Employer:
Gap Cover *(please circle)*: Yes No	**SECOND PARENT DETAILS**
Main Member:	Full Names:
Main Member ID *(if not a parent)*:	RSA ID Number:
Medical Aid:	or Birth Date:
Plan:	Address *(if different)*:
Medical Aid Number:	
Patient Dependent Code:	Post Code:
Consent to Discovery Health ID *(please circle)*: Yes No	Home Phone:
Billing Structure:	Cell Phone:
Consultation fees are billed in accordance with medical aid rates and increase annually. Please confirm current fees with reception at the time of booking.	Email:
	Work Phone:
	Occupation:
Fees apply for writing of repeat or chronic scripts; chronic benefit applications; motivational letters; medical reports/summaries and telephonic consults.	Employer:
	NEXT OF KIN/OTHER CONTACT
You may be liable for the full consultation fee if your appointment is not cancelled 24hrs in advance	Full Names:
	Relationship to Patient:
	Contact Number:
PLEASE NOTE THE FOLLOWING TERMS & CONDITIONS:	Email:

I, the undersigned, understand I am responsible for this account. And that any amount unpaid by my medical scheme, for whatsoever reason, should be settled immediately following the appointment. I agree that I have been provided with a copy of the practice's billing policy, that I have read the policy and understand the contents of the policy and the manner in which the practice bills. In the event of any legal action being instituted against me for recovery of any amount whatsoever, I shall be liable for all legal costs including admin costs and a 20% admin fee on each instalment paid. If the matter is defended, I will be liable for legal costs incurred on an attorney/client scale. Once my account has been handed over there will be no further correspondence entered in to with the practice. All correspondence will be with Nicol Davis Attorneys. The National Credit Act 34 of 2005 is not applicable to this claim. I hereby choose my above address as my domicilium citandi et executandi for all purposes under this agreement. I HAVE READ, UNDERSTAND AND AGREE TO THE CONDITITONS MENTIONED ABOVE. I CONFIRM THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT.

I hereby grant my consent to the Health Care Practitioner and appointed processor, permission for personal and clinical information to be used/shared/stored in accordance with the terms of the provisions of the Personal Information Act.

Signed: ..... Date: .....

www.chestandallergy.co.za
T: 021 003 7274 | F: 086 515 8525 | AH: 021 712 6699 | drkarabus@chestandallergy.co.za
Suite 1610, Christiaan Barnard Memorial Hospital, 25 D.F. Malan Street, Cape Town City Centre, 8000 | PO Box 16280, Vlaeberg, 8018