FEE AGREEMENT ENTERED INTO BETWEEN DR KATIE HAMILTON INC AND PERSON RESPONSIBLE FOR ACCOUNT / PATIENT (delete inapplicable)

Name: ___________________________________**ID**:___________________________________

(hereinafter referred to as "the responsible person")

Patient Name: ____________________________ **ID**:___________________________________

(hereinafter referred to as "the patient")

and

Dr Katie Hamilton Inc.'s psychology practice

(hereinafter referred to as "the psychologist")

The responsible person / patient hereby agrees as follows:

1. That (s)he is liable to pay for services rendered by the psychologist practice to the patient and, to the extent that it is applicable, (s)he is the parent / legal guardian of the patient;
2. **To pay within 30 days the account** of the psychologist in accordance with the tariff of charges prevailing in the psychologist's practice
3. To settle the psychologist's account timeously and in full, as agreed, irrespective of contracts / agreements / arrangements (s)he may have with any medical scheme or any third party;
4. To pay simple interest on any outstanding amounts due to the psychologist for the medical services rendered at the rate of 24% per annum (i.e. 2% per month) from the date of rendering the abovementioned services until date of final payment, both days inclusive;
5. Should the psychologist institute legal action against the responsible person / patient for recovery of any outstanding debts, to pay all legal costs, including attorney and own client costs, collection fees and tracing fees;
6. It is acknowledged that, in accordance with the provisions of Section 53(1) of the Health Professions Act of 1974 (duly amended) and Section 6(c) of the National Health Act 61 of 2003, the costs associated with all medical services rendered by the psychologist, treatment and / or procedures have been discussed and were fully explained to the responsible person and / or patient, to the extent required in law and professional ethics;
7. In accordance with requirements, the psychologist is granted permission to disclose any information about the responsible person and / or the patient, including medical information and / or diagnoses or diagnostic codes, to relevant third parties (such as funders, administrators, switching companies, prescriptions to pharmacies, and the like) for purposes of processing payment of accounts and in respect of medicines dispensed and / or medical services rendered to the responsible person / patient;
8. In accordance with specific Acts or statutes, professional ethics or formal policies or directives applicable to the situation, that the doctor may release the ICD 10 codes to the funders and fellow medical professionals. The responsible person and / or patient have been informed that, in certain circumstances, such as disclosure of ICD 10 codes, the exact consequences of disclosing such information is unknown to the doctor and that information relating to these consequences must be obtained by the responsible person and / or patient from the third party to whom the information is disclosed.

Initial: ______________

Practice: 1218271 • admin@katiehamilton.co.za • cell: 083 413 5797

Room 311 East Wing, Mediclinic Morningside Hospital • 78 Wilton Ave, Bryanston

www.katiehamilton.co.za

Fees:

The first appointment requires payment on the day of R1400.00. Thereafter I will charge standard medical aid rates. Cash rates are based on the Discovery Health rates. All telephonic consultations will be charged (except for first call to make the appointment), as will all reports (R2400.00).

If the responsible person does not inform the practice of cancellation of an appointment with at least a 24 hour notice period, the responsible person will remain responsible for settling the full account for the consultation, which will not be covered by medical aid.

PERSON RESPONSIBLE FOR ACCOUNT	
Full Name:	ID No.:
Email address for account:	Cell Number: **Initial:** ______________

Medical Aid:

If the patient's account is not settled by medical aid, responsible person must settle outstanding accounts within 30 days of notification. If the account is not settled within 30 days, no further consultations will be offered.

MEDICAL AID	
Medical Scheme & Plan:	Medical Aid Membership Number:
Principal Member Name & ID:	

Consent:

I, the responsible person, have read and agree with the above content, and sign this document at

___________________________________.

PATIENT / RESPONSIBLE PERSON		
Full Name	Signature	Date

NEUROPSYCHOLOGIST		
Full Name	Signature	Date

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PATIENT	
Full Name:	
ID No.:	
Age:	
Email Address	
Cell Number:	
Physical Address:	
EMERGENCY CONTACT	
Name:	
Cell number:	
Relationship to patient:	

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NEUROPSYCHOLOGY: INTAKE QUESTIONNAIRE.

REFERRAL INFORMATION	
Reason for referral:	
Referred by:	
MEDICAL / REHABILITATION TEAM	
Please provide the names of your treatment team if you are seeing any of the following:	
GP:	
Psychiatrist:	
Psychologist / Counsellor:	
Neurologist:	
Neurosurgeon:	
Speech Therapist:	
Physiotherapist:	
Occupational Therapist:	
Other relevant medical / clinical professionals:	
MEDICATION	
Please list all medications and reasons for taking them:	

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HEALTH		
Have you experienced any of these illnesses/incidents that could affect neurological functioning:	☐ Concussion ☐ Stroke ☐ Heart Attack ☐ Heart Disease ☐ Seizure / Epilepsy ☐ Meningitis / Encephalitis ☐ Traumatic Brain Injury ☐ Cancer ☐ Psychiatric Diagnosis (e.g. Depression, Anxiety, Bipolar Disorder, etc.)	
Please list all current medical diagnoses:		
Dominant hand:	☐ Left handed ☐ Right handed ☐ Ambidextrous	
EMPLOYMENT & EDUCATION		
Employment status:	☐ Working ☐ Retired ☐ Unemployed but able to work	Medical Boarding ☐ Temporary ☐ Permanent
Current job title (or last job title if currently not working):		
Highest Level of Education:		

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