

ADMISSION FORM

Kindly send the admission form to the hospital main reception for processing . Please bring along your personal documentation (Medical Aid Card & ID / Passport). Any missing information will be requested on admission .



PATIENT DETAILS					
Title		First Name(s)		Surname	
Age		Date of Birth		Religion	Nationality
ID / Passport No.				Language	
Physical Address					
					Code
Postal Address					Code
Cell No.				E-mail	
Tel No				Tel No (W)	
Employer Name				Occupation	
Company Address					
					Code

ADMISSION DETAILS (Information to be obtained from Doctor)			
Date of Admission		Diagnosis	
Admitting Doctor		PR Number	
Referring Doctor		PR Number	
Family Doctor / GP			
ICD 10 Codes		Procedure Codes	

NEXT OF KIN			
Title		First Name(s)	
Surname		Relationship to Patient	
Postal Address			Code
Cell No.		Tel No (H)	

CONTACT PERSON (NON-FAMILY)			
Title		First Name(s)	
Surname		Relationship to Patient	
Postal Address			Code
Cell No.		Tel No (H)	

MEDICAL AID DETAILS					
Medical Scheme Name		Membership No.		Dependant Code	
Plan Option		Authorisation No.		Join Date	

PERSON RESPONSIBLE FOR ACCOUNT / MAIN MEMBER					
Title		First Name(s)			
Surname		Relationship to Patient			
ID / Passport No.		Date of Birth			
Physical Address					
				Code	
Postal Address					Code
Cell No.			Email		
Tel No (H)			Tel No (W)		
Employer Name			Occupation		
Company Address					Code

I am fully conversant with the terms and conditions for admission and payment of hospital accounts.

Print Name and Surname: _____ Date _____ Signature _____

BOTSHILU PRIVATE HOSPITAL (PTY)(Ltd) TERMS AND CONDITIONS

TERMS AND CONDITIONS	This means the “Contract” between Botshilu Private Hospital (Pty) Limited (Botshilu Private Hospital or BPH) and the undersigned signatories (together the “parties”) creating contractual obligations and rights between the parties.
BOTSHILU PRIVATE	Means the registered medical facility Botshilu Private Hospital, its holding, subsidiary and associated companies and all of those companies’ Hospital directors, officers, employees and/or agents, as well as any hospital, clinic or medical facility owned and /or operated by Phelang Bonolo HealthCare Solutions (Pty) Limited or its holding, subsidiary and associated companies (“the Phelang Bonolo Group”)
GUARANTOR	Means any person who signs these terms and conditions independently from the patient or his/her parent/guardian, who accepts responsibility for the payment of the hospital account. The Guarantor remains responsible for any outstanding amount, unless full payment of the account is effected by any other party.
THIRD PARTY	This includes but is not limited to Medical Practitioners, doctors, radiologists, physiotherapists, medical aids, medical insurance providers, ambulance services or any other service providers who form part and parcel of providing patient care and/or are involved with the patient’s care.
PAYMENT OF THE ACCOUNT	I/ we the undersigned hereby agree to pay the Hospital account free of any deduction and take full responsibility for any amount owed to Botshilu Private Hospital in respect if the services rendered to the patient.
PAYMENT TERMS OF THE ACCOUNT	The account becomes due and payable immediately on the date that the account is presented.
DEPOSIT	BPH may request a deposit, which is payable immediately. Payment methods will include cash, EFT or credit card/debit card.
RECOVERY OF COST	Where the guarantor has failed to pay the hospital account, or part thereof, BPH or its successor in title has the right to recover any legal costs incurred to recover the amount due to BPH or its successor in title. Attorney fees on the scale between an attorney and his own client, plus mora interest thereon, will be recoverable from and paid directly by the Guarantor.
SIGNATORIES	Includes the patient, guarantor, parents(s) and guardian, where the patient is a minor or surety together or separately where the signatory has signed in that capacity.
SIGNATORIES PERSONALLY RESPONSIBLE	I/ we, the undersigned, the signatories, agree that I/we will be responsible for payment of the whole of the account, whether this was submitted to any medical scheme or any other party for payment.
MINOR PATIENTS	Where the patient is a minor, that is unmarried and below the age of 18 years, both the minor`s parents and /or guardians sign these terms and conditions in both their personal and representative capacities and in so doing accept responsibility for payment of the account in full.
CONSENT TO ACCESS CREDIT INFORMATION	I/ we, the undersigned, consent to BPH obtaining any information concerning my credit profile and payment history from any credit bureau, or any other institution with whom I/we, the undersigned may have financial dealings.
VERIFICATION OF ADDRESS AND EMPLOYMENT	I, we the undersigned hereby consent to BPH verifying address/es and employment information of any signatories.
SOUTH AFRICAN JURISDICTION AND LAW	This Contract and the use of the BPH facility, and any health services provided by BPH to the patient, will be governed by and construed in accordance with the laws of the Republic of South Africa.
CONSENT TO MAGISTRATES COURT	I/we, the undersigned, hereby consent and submit, in terms of section 45 of the Magistrates` Courts Act, to the jurisdiction of the appropriate Magistrates` Court in respect of all actions or other proceedings, which might be brought against me/ us by or on behalf of BPH arising out of my/our failure to pay any amount owing to BPH or its successors in title or any other breach of the this Contract, irrespective of the value of the claim against me/us.
PATIENT CONSENT TO DISCLOSURE OF INFORMATION	<p>I, the patient, personally or duly represented as aforesaid, hereby provide my express consent to BPH to process my personal information, as defined in relevant legislation, for purpose of providing medical and similar services and to share such personal information with third parties in order to provide such medical and related services to me. I Further authorize BPH to release any records or copies of records in relation thereof, to my medical aid.</p> <p>Patient Signature _____</p>
ACCOUNTS AND INVOICES	<p>I, the patient, hereby authorize BPH to provide to the Guarantor, or Main Member of my medical aid, any account and/ or statement or copy thereof relating to the services rendered to me by Botshilu Private Hospital.</p> <p>Patient Signature _____</p>
EMAIL AND MOBILE INFORMATION AND USAGE	I/we the undersigned, hereby give consent to Botshilu Private Hospital to utilize the email address and/or mobile phone number as provided by me in the admission form of the patient and guarantor, for communication or accounts or invoices relating to the services rendered to me by Botshilu Private Hospital and accept that address as my domicilium citandi et executandi in respect of any legal process.
MEDICAL PRACTITIONERS AND THIRD PARTY TREATMENT AND ACCOUNTS	I,/we the undersigned, understand and accept that the casualty (ER) department, the medical practitioners, doctors, radiologists, physiotherapists, specialists and other such practitioners who treat the patient, are independent contractors who are not employed by Botshilu Private Hospital and that Botshilu Private Hospital is not responsible for payment of their invoices or for any treatment rendered by them or any consequence thereof
DISCLAIMER IN RESPECT OF PERSONAL PROPERTY	<p>I/we the undersigned, understand accept and agree that Botshilu Private Hospital will not be liable or responsible for any loss of, damage or destruction to any property, including money and valuables, belonging to me or in my possession, or given to Botshilu Private Hospital for safekeeping, even if Botshilu Private Hospital is/was negligent in any way, no matter how the loss, damage or destruction was caused.</p> <p>Patient Signature _____</p>
DISCLAIMER IN RESPECT OF INFECTIONS CONTAINED IN THE HOSPITAL	<p>I/we the undersigned, understand accept and agree that Botshilu Private Hospital does treat and assist patients with different problems and diseases, including patients who might be affected with highly contagious diseases such as Ebola and Covid 19. I/we understand that in attempting to ensure proper systems are in place to safeguard all other patients, staff and doctors, I will not hold the hospital liable in any manner whatsoever should I become infected with such diseases while in hospital. I accept all responsibility to cooperate and work with hospital staff and doctors when they advise me what to do and how best to protect myself, should it be so required.</p> <p>Patient Signature _____</p>
TERMS AND CONDITIONS READ AND UNDERSTOOD	I/we, the undersigned, certify that I/we, have read, understood and agree to these terms and conditions.

SIGNED AT _____ ON THIS _____ DAY OF _____ 20 _____

PATIENT (full name(s))

(signature)

MAIN MEMBER / GUARANTOR

(signature)

PARENT(S) OR GUARDIAN(S) (if minor child) (full name(s))

(signature)

BOTSHILU STAFF MEMBER: (full name(s))

(signature)