



CONSENT TO TREAT, INFORMATION SHARING AND FINANCIAL AGREEMENT

1. PATIENT AND PARENT/GUARDIAN DETAILS

I, _____ (ID Number: _____) am the parent/legal guardian of: Child's Name:
_____ Date of Birth: ____ / ____ / ____

2. GENERAL CONSENT TO MEDICAL ASSESSMENT AND TREATMENT

I hereby consent to my child being examined, assessed and treated by the medical practitioners practising at Paediatrics on Broadway. I understand that medical care may include, here clinically indicated:

- Clinical examinations and diagnostic assessments
- Prescription of medication
- Advice and therapeutic interventions
- Referral to independent healthcare practitioners
- Hospital admission where required
- Intravenous fluids and medications
- Nutritional support including formula, supplementation or tube feeding
- Routine bedside procedures such as peripheral IV insertion, bladder catheterisation, nasogastric tube placement and other similar interventions

I acknowledge that:

- All medical treatment carries inherent risks and potential complications.
- The practitioner will explain material risks, benefits and alternatives relevant to my child's condition before significant or invasive procedures are performed.
- I am encouraged to ask questions and may request further clarification before consenting to any treatment.
- I may withdraw consent at any time, subject to the clinical safety of my child.

This general consent does not replace the requirement for specific informed consent for invasive or high-risk procedures where separate written consent is clinically required. In the event of a medical emergency where immediate treatment is necessary to prevent serious harm and I am not available, I authorise the practitioner to provide emergency treatment in my child's best interests.

3. INVOLVEMENT OF OTHER HEALTHCARE PROVIDERS

I understand that comprehensive care may involve other independent healthcare providers, including but not limited to:

- Dietitians
- Audiologists
- Speech therapists
- Physiotherapists
- Paediatric surgeons or subspecialists
- Pathology laboratories
- Radiology and nuclear medicine services

Where hospitalisation is required, hospital facilities, nursing services and equipment are provided by the relevant hospital, which operates as an independent entity. Each healthcare provider is responsible for the services rendered within their own professional scope of practice.



4. PROCESSING OF PERSONAL INFORMATION (POPIA)

In order to provide appropriate medical care, the practice collects and processes personal and medical information relating to the child and family. I hereby consent to the collection, storage and sharing of relevant personal and medical information between healthcare providers involved in my child's care, strictly for the purpose of diagnosis, treatment, administration and lawful billing. The practice processes personal information in accordance with the Protection of Personal Information Act (POPIA).

I understand that:

- I may request access to or correction of personal information held by the practice.
- A copy of the practice Privacy Policy is available on request.
- Complaints relating to personal information may be lodged with the Information Regulator of South Africa.

Personal information will not be used for marketing purposes without separate consent.

5. FEES, MEDICAL SCHEME CLAIMS AND PAYMENT RESPONSIBILITY

Each doctor practises independently and may be contracted with certain medical schemes. Where a doctor is contracted with your medical scheme, fees will be charged in accordance with that agreement. Where no contract exists between the doctor and your medical scheme:

- The practice fee may differ from the scheme benefit.
- You remain personally responsible for any shortfall or for the full account where no benefit is available.

Submission of a claim to a medical scheme does not guarantee payment by the scheme. It remains the parent/guardian's responsibility to ensure that accounts are settled. Accounts not settled within 60 days may be handed over for collection in accordance with applicable legislation. Collection costs permitted by law may be added to the outstanding balance.

Account queries may be directed to the Practice Manager at 021 948 1751.

Account queries for Dr Andrag: 021 202 1685

6. ACKNOWLEDGEMENT

By signing below, I confirm that:

- I have read and understood this document.
- I have had the opportunity to ask questions.
- I consent to the medical assessment and treatment of my child as described above.
- I accept responsibility for the financial obligations arising from services rendered.

Signed at _____ on this _____ day of _____ 20____.

Parent/Guardian Signature: _____

Full Name: _____

Contact Number: _____