INTERCARE GLEN MARAIS:

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DR J.W. BERGMAN | DR J.L. ROSS | DR B.A. COTTON | DR J.V. BEKKER | DR J.C. BASSON
DR Y. VADACHIA | DR M.A. HAYES | DR A.D. BRANDT | DR A. SABAN | DR S. FAYKER

Request for Imaging Examinations

Date:	**Date of Birth:**
Name:	**ICD 10 Code:**
Medical Aid:	**Medical Aid No:**
Dependant:	
Code Tariff:	**Authorisation No:**
Code:	

EXAMINATION: ☐ X-RAY ☐ ULTRASOUND

CLINICAL PARTICULARS

REFERRING DOCTOR: _____ **TEL NO.:** _____

SIGNATURE: _____ **EMAIL:** _____

PRACTICE NO.: _____ **RESULTS EMAIL:** _____

FEMALE PATIENTS: ARE YOU PREGNANT? YES | NO

INDEMNIFICATION AND CONSENT

- I confirm that the information supplied is true and correct. I agree and understand that: • The member will carry all costs/ penalties incurred as a result of failed pre-authorisation. Should legal steps be instituted for the collection of outstanding funds, I shall be liable for costs of an attorney/ client scale.
- Notwithstanding any Medical Aid Society or other organisation's undertaking, I acknowledge personal responsibility for the payment of the account within 30 days. As a Private Patient/ without a valid medical aid, I agree to pay for the procedure/examination on the day.
- I authorise and give consent to Bergman Ross & Partners to release my medical reports. Diagnostic images and referral letters for the purpose of mediation my adiology account with my medical aid, as well as government institutions for statistical purposes.
- All procedures performed at this facility will be online and available to a restricted community of clinicians. I hereby give consent for my radiology images and reports to be released to all 3rd parties forming part of my circle of healthcare as per conditions of the POP (PAIA) Act of 2013.

Patient Signature: _____ **Patient Name:** _____ **Date:** _____