## FINANCIAL AGEEMENT

**PATIENT NAME:** ________________________________________________

I, the undersigned, patient, guardian or legal representatives hereby agree that:

**1. Treatment & Fees Understanding:**

- Prior to commencing with any treatment, I will ensure that have been informed about the recommended treatment and fees, and understand the costs estimates.
- I have been informed that the fees charged by this practice are determined by the appropriateness, complexity and time required for execution of such care thereby maintaining optimal standard of services rendered by this practice.
- Cancellations require at least 48 hours' notice for appointments lasting one hour or less, and 72 hours appointments longer than one hour. Missed or late-cancelled appointments are subject to a cancellation fee.
- Patients who miss appointments or cancel with short notice may need to pay a 50% deposit for future bookings.

**2. Responsibility for Payment:**

- Matrix Dental Specialists is not bound by medical aid scheme contract or rates. Patients are responsible for settling all fees directly with Matrix Dental Specialists.
- A 50% deposit is required before surgery to secure cost of materials required for treatment, including implants, biomaterials and laboratory fees.
- For hospital procedures, patients must obtain medical aid authorization where required, with the practice providing assistance if needed.
- **Full payment is due immediately after treatment at the practice** and within 10 working days after surgical procedures in the hospital.
- Matrix Dental Specialists does not submit claims on behalf of patients. All payments are made directly to the practice. You may submit claims to your medical aid independently.

**3. Other Health Professionals:**

- Fees for other health professionals involved, like anaesthetists, hospitals and other surgeons, are not included in the fees invoiced by Matrix Dental Specialists.

**DECLARATION BY PATIENT OR GUARDIAN:**

- I hereby declare that practitioner's fees have been fully explained to me.
- Furthermore, I declare that I understand and voluntarily authorize and request Matrix Dental Specialists to perform the recommended treatment.
- I acknowledge that it is my responsibility to confirm with my health insurance fund the level of cover that I have and any amount that will not be reimbursed.
- I have been advised that other health professionals may be involved in my treatment and I understand that Matrix Dental Specialists will provide quotations for work to be performed by Dr F Bhamjee; Dr R Haffajee and Dr I Mayet and other practioners within Matrix Dental Specialists.

________________________________________ ________________________________________

Patient Signature Date

## PATIENT INFORMATION

Surname: ______________________ Title: __________

First Name: ______________________ Date of birth: __________

ID/Passport Number: ______________________

Address: ______________________

Email: ______________________ Contact No: __________

Emergency Contact: ______________________ Contact No: __________

Relationship to patient: ○ Partner ○ Parent ○ Child ○ Friend ○ Other __________

Referred by: ______________________

## PERSON RESPONSIBLE FOR ACCOUNT/MAIN MEMBER

Surname: ______________________ Title: __________

First Name: ______________________ Date of birth: __________

ID/Passport Number: ______________________

Email: ______________________ Contact No: __________

Relationship to patient: ○ Partner ○ Parent ○ Child ○ Friend ○ Other __________

## MEDICAL HISTORY

General Practioner: ______________________

Allergies: ______________________

Chronic Conditions: ______________________

Chronic Medication: ______________________

## MEDICAL AID DETAILS

○ Private

Medical Scheme: ______________ Plan: ______________

Membership Number: ______________________ Dependant Code: __________

Main Member: ______________________ Main Member ID: __________

______________________ ______________________

Patient Signature Date

Dr Ridhwaan Haffajee
Prosthodontist
BCHD (UWC), Postgraduate Diploma in Implantology (UWC)

Dr Feheem Bhamjee
Oral Medicine and Periodontal Specialist
MCHD OMP (UWC), PDD Implantology (UWC),
Dip Odont Oral Surgery

Dr Imraan Mayet
General Dentist and Invisalign Provider
BChD (UWC), Postgraduate Diploma in Orthodontics (UWC)

## CLINICAL PHOTOGRAPHY CONSENT FORM

Clinical photographs are an essential part of record-keeping, diagnosis, and treatment planning for your case. Additionally, photography plays a role in the education of medical and dental professionals at various levels, benefiting future patients. Furthermore photography may also be used for marketing material.

To ensure that you are fully informed and comfortable, we offer three levels of consent. Your level of consent will not affect your treatment in any way. **Regardless of the level of consent you choose, your identity will be protected at all times.**

Please select the level(s) you are consenting to:

○ **Consent Type A: Open Publication Use**
I consent to my photographs being used for open publication, such as journals, textbooks, display materials, information leaflets, or websites that may be accessible to both the general public and medical professionals.

○ **Consent Type B: Restricted Educational Use**
I consent to photographs being used to educate other medical professionals at professional events such as presentations, lectures, or in publications intended for medical/dental professionals or students.

○ **Consent Type C: Clinical Use**
I consent that the photographs requested will be used as part of my confidential treatment records and case notes only. These will not be used for teaching or marketing purposes.

I understand that I have the right to withdraw this consent at any time by notifying you in writing.

______________________________
Patient Name

______________________________
Patient Signature

______________________________
Date

Dr Ridhwaan Haffajee
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MATRIX DENTAL SPECIALISTS
SHOWROOM A, THE MATRIX BUILDING, 8 BRIDGEWAY, CENTURY CITY, 7441
reception@matrixdental.co.za - 021 110 5764

## CONSENT FOR THE PROCESSING AND USE OF PERSONAL INFORMATION

INFORMED CONSENT PROVIDED BY PATIENT/PARENT/GUARDIAN IN TERMS OF **THE PROTECTION OF PERSONAL INFORMATION ACT 4 OF 2013 (POPIA)** FOR PERSONAL INFORMATION TO BE COLLECTED AND PROCESSED BY **Matrix Dental Specialists and Associated Clinicians** ("the responsible party", "practice" and also "the company").

I, ______________________________________________ the undersigned hereby consent to the processing of my personal information or that of my child as contemplated in the Protection of Personal Information Act No 4 of 2013, by the practice, the practice staff and third party with whom the practice has a contractual relationship for the following purposes:

1. Identifying and/or verifying the patient's or dependent's details.
2. Treating and managing me and/or my child in terms of a dentist-and-patient relationship.
3. Further processing or the administration of the contractual relationship between myself and the practice.
4. Legal or contractual purposes.
5. Communicating with other persons as it relates to my treatment and management.
6. Communicating with third parties who have undertaken to indemnify me for the costs of my treatment and management or part thereof, including medical schemes and their administrators where relevant.
7. Recovering unpaid monies and/or any other amount due to the practice.
8. Debt collection.
9. Identifying other products and services which might be of interest to the patients.
10. Informing patients about the practice's products and services.
11. Processing is necessary for pursuing the legitimate interest of the practice or the third party to whom the information is supplied.

**Withholding Consent.** I understand that it the policy of the practice to require all patients complete and sign the consent. If I exercise my right to withhold my consent to the practice collecting and processing Personal Information, I understand and agree that in this case, the practice reserves the right not to provide dental services (except emergencies) and for which I take full responsibility and indemnify the Practice.

**Withdrawal.** I understand that I can withdraw this consent at any time and I undertake to inform the practice of my withdrawal. In this case, I understand that this may affect my rights and contractual relationship that I have with the practice and for which I take full liability and hereby indemnify the practice.

My consent is provided of my own free will without any undue influence from any person whatsoever. I confirm that I have permission of my dependant(s) to give their consent, where such consent has been provided and I indemnify the practice against this.

The Practice Information Officer details are:
Dr Ridhwaan Haffajee    Tel: (021) 110- 5764    Email: reception@matrixdental.co.za

______________________ ______________________ ______________________
Patient/Guardian Signature    Printed Name of Patient/Guardian    Date

Email address: ______________________ Cell No: ______________________

______________________ ______________________ ______________________
Witness Signature    Witness initial and surname    Date