Dr Ian Grundlingh
Prosthodontist

DR A.A.GRUNDLINGH
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POPI ACT: APPROVAL FOR ACCESS, USE AND PROCESSING OF PRIVATE INFORMATION:

I the undersigned ____
FULL NAMES AND SURNAME

____
ID/PASSPORT NUMBER

Give hereby my consent that my personal information can be shared with referring clinicians and debt collectors of the practice accounts .

Dated at ____________________ on this ______ day of ___________________

Signature ________________________________

Accounts Liability

*All treatment costs are payable by the patient directly after every procedure, as the practice does not submit any claims to medical aid funds. This will remain the responsibility of the patient.
*The final treatment costs are payable before the placement of the permanent crowns, bridges or prostheses.
*The quotation only provides details pertaining to a cost estimate of the proposed treatment.
*The final treatment plan and costs may differ from the proposed treatment plan, as every treatment is determined by the clinical circumstance. This will, however, be discussed with the patient.
*Due to fluctuation in the exchange rates and material costs, the laboratory fees and implant component fees may differ from the amounts in the costs estimates.
* The laboratory costs mentioned (code 8099) is directly payable to the laboratory.
*The practice charges fees that are above the National Health Reference Price list (NHRPL). The website for the Health Professions Council of South Africa is WWW.HPCSA.CO.ZA
*This cost estimate does not include any surgical fees and implant component costs related. The Surgeon involved will provide the cost estimate for any surgical treatment to be undertaken.
*After finalization of the treatment, you will be placed on a specifically prepared maintenance program.
*Costs are valid for 3 months.
*Any disputes will be handled in South Africa under the HPCSA

***I HEREBY ACKNOWLEDGE AND AGREE THAT BY MY SIGNATURE HERETO I WILL BE HELD LIABLE FOR THE DUE PAYMENT OF ALL AMOUNTS WHICH MAY NOW OR AT ANY TIME HEREAFTER BECOME PAYABLE(ACCOUNTS ARE PAYABLE ON PRESENTATION)**
*** I AGREE TO PAY ALL LEGAL CHARGES ON THE ATTORNEY AND CLIENT SCALE INCLUDING COLLECTION COMMISSION SHOULD LEGAL ACTION BE INSTITUTED AGAINST ME.**
*** I NOMINATE THE ADDRESS ABOVE UNDER RESIDENTIAL ADDRESS AS MY DOMICILIUM CITANDI ET EXECUTANDI.**

PATIENT SIGNATURE