

ROWIN RAGHUBIR RADIOGRAPHY



X-RAY ~ ULTRASOUND ~ BMD REQUEST FORM

TEL: 031 207 4723 TEL/FAX: 031 207 4687 AFTERHOURS CELL: 076 411 2704

11 BAZLEY AVENUE, SYDENHAM MEDICAL CENTRE, SYDENHAM, 4091

EMAIL: ADMIN@RRRAD.CO.ZA PRACTICE NUMBER: 0500704 WEBSITE: WWW.RRRAD.CO.ZA

PATIENT INFORMATION

PATIENT NAME _____ SURNAME _____

TITLE _____ ID/PASSPORT No. _____ D.O.B _____ AGE _____

RELATION TO MEMBER _____ DEPENDENT CODE _____

FEMALE PATIENTS: PREGNANT? YES / NO LAST MENSTRUAL PERIOD _____

EMAIL ADDRESS _____ CELL _____

PERSON RESPONSIBLE FOR PAYMENT/MAIN MEMBER

NAME _____ SURNAME _____

TITLE _____ INITIAL _____ ID/PASSPORT NO. _____ D.O.B _____

MEDICAL AID _____

MEDICAL AID NUMBER _____ PLAN OPTION _____

RESIDENTIAL ADDRESS _____

_____ CODE _____

POSTAL ADDRESS _____

TEL. WORK _____ CELL _____ HOME _____

E-MAIL _____ FAX _____

OCCUPATION _____ EMPLOYER _____

WORK ADDRESS _____

RELATIVE/FRIEND _____ RELATIVE TEL. _____

TO BE COMPLETED BY REFERRING DOCTOR

CLINICAL DETAILS / HISTORY / MOTIVATION / SUSPECTED CONDITION: _____ ICD-10 CODE _____

EXAMINATION REQUEST _____ DATE _____

BONE DENSITY **BODY COMPOSITION INCLUDING VISCERAL FAT (VAT)**

REFERRING DOCTORS NAME: _____ SIGN: _____

TEL. WORK _____ CELL _____ FAX _____

E-MAIL ADDRESS _____ PR. No. _____

DECLARATION

I CERTIFY THAT THE DETAILS ON REVERSE OF THIS PAGE ARE CORRECT AND FURTHER ACCEPT ON BEHALF OF THE **MEMBER / MYSELF** PERSONAL RESPONSIBILITY FOR THE PAYMENT IN FULL OF ANY REASONABLE AMOUNT INCURRED IN RELATION TO RADIOGRAPHIC PROCEDURES PERFORMED, THIS IS IRRESPECTIVE OF ANY THIRD PARTY SUCH AS MEDICAL AID / ANY OTHER MEDICAL INSURANCE. WHERE CLAIMS ARE SUBMITTED TO A MEDICAL SCHEME AND ADDITIONAL MOTIVATION IS REQUIRED FOR PAYMENT AN ADMINISTRATIVE CHARGE WILL BE IMPLEMENTED AT THE SOLE DISCRETION OF R RAGHUBIR RADIOGRAPHY.

I AGREE TO HAVE THESE EXAMINATIONS WITH ALL IMAGING TECHNIQUES/POSITIONS DEEMED NECESSARY BY THE PRACTITIONER.

I HEREBY ACKNOWLEDGE DEBT TO **R RAGHUBIR RADIOGRAPHY** AND BIND MYSELF TO PAY THE FULL AMOUNT OUTSTANDING BY NO LATER THAN 30 DAYS FROM DATE OF SERVICE SHOULD THE MEDICAL SCHEME HAVE NOT PAID BY THIS DATE.

R RAGHUBIR RADIOGRAPHY SHALL HAVE IRREVOCABLE RIGHTS TO RECOVER SAID DEBTS FROM MYSELF AND I ACCEPT FULL RESPONSIBILITY TO PAY FOR LEGAL AND ADMINISTRATIVE COSTS INCURRED AND CHARGED BY **R RAGHUBIR RADIOGRAPHY** AS A RESULT THEREOF.

I FURTHER AGREE TO PAY ANY INTEREST CHARGED IF PAYMENT IS NOT MADE WITHIN 30 DAYS.

I UNDERSTAND AND ACCEPT THAT IF APPLICABLE MY MEDICAL AID WILL BE CHARGED SEPARATELY FOR THE REPORT BY THE SPECIALIST

I HEREBY GIVE PERMISSION FOR THE ICD 10 CODE TO BE REVEALED TO MY MEDICAL AID

SIGNATURE _____ DATE _____

FULL NAME OF SIGNATORY _____

WITNESS _____

FOR INTERNAL USE ONLY

ACCOUNT NUMBER _____ DATE OF PROCEDURE _____

RECEPTIONIST _____

CHARGE AS: PVT MED AID OCHEALTH DCS RAF A/H OTHER IN HOSPITAL ATTRNY

AMOUNT RECEIVED: CASH _____ CARD _____ M/A _____ EDCON _____

RECEIPT NUMBER _____

RADIOGRAPHERS COMMENTS

BILLING COMMENTS

RECEPTIONISTS COMMENTS

STAMPS

