



DR JACQUES DOUBELL

CONSENT TO TREATMENT

Patient full names and surname: _____

Patient identity number: _____

Patient medical scheme name and number: _____

I, the Patient, by signing this form, confirm that:

1. Dr Jacques Doubell has spoken to me about my **health status**, i.e. how my health appears to be, or how he has evaluated my health. If another healthcare practitioner (doctor, nurse or physiotherapist, psychologist, for example) has referred me to Dr Jacques Doubell, this referral was discussed with me.
2. Dr Jacques Doubell has explained to me what my **options** of health care are. I understand these options and have consented to the treatment / treatment plan, described as follows: _____

3. I understand what this health care **means, and what it will take from me**. I understand that, specifically, I have to consider the following (e.g. *treatment duration, importance of taking medication, coming back to the Practice as instructed, following self-care and how I must behave or things I must not do, etc.*): _____

4. I have been told about the **benefits, risks and costs** of the health care. I understand the risks, and agree to those risks, which includes: _____

_____ **PATIENT INITIALS**

I understand that the **price** related to the health care are subject to the agreement I signed with the practice when I first joined. I have been informed of the fees charged by Dr Jacques Doubell, and also that certain fees and costs are excluded from that fee (e.g. hospital and diagnostic tests costs). I also understand that healthcare sometimes requires more than what was anticipated, and Dr Jacques Doubell will bill for all such healthcare reasonably rendered. Some consultations are time-based, and if more time is taken to address my healthcare, such extended time will be billed for.

5. I understand that I can **refuse** health care at any stage, but also understand that if I refuse, Dr Jacques Doubell must explain the consequences of the refusal to me. I will then not hold Dr Jacques Doubell or the practice liable for any of those consequences, should they happen. If I refuse, I must still pay for the health care I have had up to that point.

Signed at _____ (place) on _____ (date).

Patient's Name: _____ Patient's Signature: _____

Dr Jacques Doubell: _____

Doubell Cardiology Inc

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