General Consent Form

I…………... ………….. hereby consent to receiving the following treatment ………………….. on the ……/......…/…… by Dr ……………….

Although your medical aid has authorized (Auth number …………) the above procedure, in this situation, you will be liable or responsible to settle the account within 30 days this is not a guarantee of payment as funds are not reserved.

If the account remains short paid or un paid I hereby acknowledge that I will be responsible to settle the outstanding account within 30 days.

Patients Name: ………………………………..

Patients Signature: …………………………….....

Date: ……../………/………..