

By Design Dental Practice

Terms and Conditions

I, the undersigned, irrevocably declare and undertake the following:

Dental records

1. That I consent to the taking of photographs and/or x-rays which will be used by the practice as patient records for treatment planning.
2. Photographs might be used for teaching, website, social media sites and informative purposes. Undersigned will be anonymous in all posted photographs. Mark X to which photographs you **DO NOT** give consent:

- | | |
|--------------------------|--------------------|
| <input type="checkbox"/> | Full Face |
| <input type="checkbox"/> | ¾ of Face |
| <input type="checkbox"/> | Mouth Extra - Oral |
| <input type="checkbox"/> | Mouth Intra - Oral |

Payment and Treatment Costs

1. That I have been fully informed that *By Design Dental Practice* is a private practice and does not charge any Medical Aid-based rates. Patients are fully responsible to settle the account on the day of treatment.
2. Treatments exceeding 90 minutes will require a 50% deposit prior to confirmation of the appointment.
3. I am aware that *By Design Dental Practice* fees are more than most Medical Aid rates and benefits.
4. I acknowledge that it is my obligation to request a written cost estimate/treatment plan before the commencement of my or any dental treatment. Additionally, I have the right to discuss the treatment plan before the commencement of dental treatment.
5. I understand that no treatment estimation will be given without **X-rays and digital photos** being taken of the patient.
6. I acknowledge that I have to consult with my medical insurer/provider on their portion of the payment of the cost estimate. The *By Design* team does not submit claims directly to medical aid providers. **I understand that the patient is liable to settle the treatment costs.**
7. I acknowledge that treatment costs must be settled in full before a detailed invoice will be provided to me to submit to the medical aid insurer. An invoice cannot be provided prior to the consultation or treatment.
8. That I accept full responsibility for my account to be settled directly after each visit.
9. If the account is not settled and this account is handed over for collection, I consent to legal fees on an attorney and client scale, collection commission, tracing fees and VAT (If applicable). The interest of 2% per month will also be payable to the *By Design Dental Practice*. Sixty-day accounts will be handed over for collection.
10. That an additional after-hour fee of R 1 500 will be charged outside normal working hours. Working hours are between 09:00 and 18:00 on weekdays.
11. That I accept one of the following payment methods: Credit Card, Debit Card, Cash, or EFT (to be made in-office).

Appointment Cancellation

1. I acknowledge that I have the right to cancel my dental appointment. Appointments should be cancelled 24 hours in advance.
2. If I cannot attend an appointment due to an emergency, it remains my responsibility to inform the *By Design* Patient Relations Manager via email, WhatsApp message or phone call.
3. I accept that a fee of R 1 500 per hour, or a portion thereof, will be charged for all appointments not kept and not cancelled 8 hours prior to the appointment.

Communication

1. I have the right to contact the *By Design* practice manager immediately if any dispute or complaint arises. Please note that communicating directly with the medical healthcare provider via social media, including WhatsApp is discouraged. Official communication should occur via the official *By Design* communication channels.
2. In the event of a contractual dispute or any cause of action, litigation shall only be instituted in a court of the Republic of South Africa.
3. That I selected the address below as my *domicilium citandi et executandi* (nominated residential address) for all purposes under the agreement.
4. That any registered notice which is forwarded to this address will be deemed to have been received five days after the date of posting.
5. I undertake to inform the *By Design Dental Practice*, in writing, one week in advance should this address change.
6. I give consent that *By Design* team practice may contact me via SMS, WhatsApp or e-mail regarding the confirmation of my appointments, and recalls and inform me of practice news.

Minors & Parents

1. As the parent/legal guardian of a minor patient, I acknowledge that I am responsible to accompany my child to treatments and treatment plan discussions.
2. As the parent/legal guardian of a minor patient acknowledge that they are responsible to settle payments of treatment in person.

Disclosure of Medical Conditions and Medication

1. I will disclose any medical condition, medication or medical treatment which could influence the success of dental procedures or treatments. If there are any changes to the disclosed medical conditions, treatments, or medication, I will inform the *By Design* team before treatment or dental procedure.

POPI Regulations

All parties agree that they will comply with POPI regulations and process all the information and/or personal data in respect of the services being rendered in accordance with the said regulation and only for the purpose of providing the services set out in the agreement to provide services.

The *By Design Dental Practice* (also service provider), all the parties to this agreement, the service provider's employees and the client's employees and any subsequent party/parties to this agreement acknowledge and confirm that:

1. One or more of the parties to this agreement will possess and will continue to possess information that may be classified or maybe deemed as private, confidential or personal information.
2. Such information may be deemed as private, confidential or personal information in so far as it relates to any party to this agreement.
3. Further, it is acknowledged and agreed by all parties to this agreement that such private, confidential or personal information may have value and such information may or may not be in the public domain.

Signed by me on this, the _____ (Date) day of _____ (Month), _____ (Year)

Full Names and Surname: _____

ID No: _____

Physical Address: _____

Postal Code: _____

Email: _____ Phone Number: _____

Medical Conditions: _____ Medications: _____

Signature: _____