



DR TIENIE VAN ROOYEN

PLASTIC AND RECONSTRUCTIVE SURGEON  
MBCHB(PRET) MMED(PLASTSURG)(PRET)

### PATIENT INFORMATION / PASIËNT INLIGTING

NAME <b>AND</b> SURNAME/ NAAM <b>EN</b> VAN:				TITLE/ TITEL:	
<b>ID NUMBER(SA CITIZENS):</b>				LANG/ TAAL:	
DATE OF BIRTH (UNDERAGE OR INTERNATIONAL PATIENTS):					
CELL/ SEL:			EMAIL/ EPOS:		
HOME NO/ HUIS NR:			WORK NO/ WERK NR:		
HOME ADDRESS/ HUISADRES:			POSTAL ADDRESS/ POSADRES:		

### PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT OR MAIN MEMBER / PERSOON VERANTWOORDELIK VIR DIE BETALING VAN REKENING OF HOOFLID

NAME <b>AND</b> SURNAME/ NAAM <b>EN</b> VAN:				TITLE/ TITEL:	
<b>ID NUMBER(SA CITIZENS):</b>				LANG/ TAAL:	
DATE OF BIRTH (UNDERAGE OR INTERNATIONAL PATIENTS):					
CELL/ SEL:			EMAIL/ EPOS:		
HOME NO/ HUIS NR:			WORK NO/ WERK NR:		
HOME ADDRESS/ HUISADRES:			POSTAL ADDRESS/ POSADRES:		

### MEDICAL AID INFORMATION / MEDIESE FONDS INLIGTING

MEDICAL AID/ MEDIESE FONDS:				
PLAN:				
NO/ NR:				
DEP. NO. / AFK NR.:				
REF. DOCTOR/ VERW. DOKTER:		TEL:		
HOUSE DOCTOR/ HUIS DOKTER:		TEL:		

### EMERGENCY CONTACT/ NOOD KONTAK

NAME <b>AND</b> SURNAME/ NAAM <b>EN</b> VAN:		CELL/ SEL:	
RELATIONSHIP/ VERWANTSAP:		TEL:	

**CONSULTATION FEE = R 1100.00**

The consultation fee is payable after the appointment.

**KONSULTASIE FOOI = R 1100.00**

U konsultasie fooi is betaalbaar na u afspraak.

**HAVE YOU EVER OR ARE YOU SUFFERING FROM ANY OF THE FOLLOWING?**

**HET U ENIGE VAN DIE VOLGENDE SIMPTOME ONLANGS ONDERVIND OF HET U 'N GESKIEDENIS DAARVAN?**

**YES**

**NO**

Do you have any contagious disease e.g. hepatitis, HIV etc.? / Het u tans enige aansteeklike siekte soos bv. hepatitis, HIV ens.?		
Diabetes		
Asthma / Asma		
Thyroid dysfunction / Skildklier wanbalans		
Porphyry / Porfirie		
Epilepsy / Epilepsie		
Gout / Jig		
Psoriasis / Psoriase		
Low blood pressure (nausea, dizziness, light-headed) / Lae bloeddruk (naarheid, duiseligheid)		
High blood pressure / Hoë bloeddruk		
Have you used Reaccutane in the last 6 months? / Het u Reaccutane gebruik in die laaste 6 maande?		
<b>SYSTEMIC ILLNESSES: Please specify / SISTEMIESE ONGESTELDHEDDE: Spesifiseer asb.</b>		
Heart disease / Hartkwale		
Lung disease / Longkwale		
Stomach disorders i.e. ulcers / Maagkwale soos bv.: maagsere		
Small intestine i.e. ulcers in small intestine / Dunderm probleme soos bv. blasies/sere van die dunderm		
Large intestine disease, i.e. spasms, diverticulitis / Dikderm probleme soos bv.: divertikulose, spasmas		
Kidney disease, i.e. kidney stones / Nierprobleme soos bv. nierstene ens.		
Liver disease, i.e. hepatitis / Lewersiekte soos bv.: hepatitis (geelsug)		
Spleen / Miltsiektes		
Neck pain, back ache / Nek of rugprobleme		
Hiatus hernia/heartburn / Mantelvliesbreuk of Sooi-brand		
Stroke / Hartaanval gehad		
Arthritis / Artritis		
<b>HISTORY / GESKIENDENIS:</b>		
Do your wounds heal badly? / Genees u wonde moeilik?		
Do you have a bleeding disorder? / Bloei u maklik/baie?		
Do you have sore spots in the nose? / Het u sere in u neus?		
Do you bruise easily? / Kneus u maklik?		
Do you smoke? For how long and how many a day? / Rook u? Hoe lank rook u al en hoeveel per dag?		
Do you use disprin? / Gebruik u disprin?		
Have you ever had blood clots in the legs? / Het u al ooit bloedklonte in u bene gehad?		
Do you have unsightly scars – raised, itchy, and painful? / Het u onooglike letsels, opgehewe, pynlik of branderig?		
Are you pregnant? / Is u swanger?		
When was your last normal menstruation date? / Wanneer was u laaste normale menstruasie datum?		
<b>REACTIONS TO ANAESTHETIC: Do you suffer side-effects from:</b>		
1. Local anesthetic (at the dentist)		
2. General anesthetic (nausea etc.)		
<b>REAKSIE NA NARKOSE: Het u gewoonlik enige reaksie na die volgende:</b>		
1. Plaaslike narkose/ sedasie soos bv. by u tandarts		
2. Algemene narkose soos bv. naarheid		
<b>PREVIOUS SURGERY: (Estimated dates and details) / VORIGE OPERASIES: (Datum en tipe operasie)</b>		
Do you take any medication? Name? What is dosage? / Neem u enige medikasie? Spesifiseer die naam en dosis:		
<b>ALLERGIES. Please specify / ALLERGIE: Spesifiseer asb.</b>		
<b>SIDE EFFECTS / NEWE EFFEKTE:</b>		
Have you suffered any unpleasant side-effects after previous surgery, i.e. infection, prolonged wound healing etc.		
Het u enige komplikasies gehad na vorige chirurgie soos bv. infeksie, verlengde wondherstel ens.?		



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## DISCLAIMER

I, \_\_\_\_\_, hereby give permission to the Practice of Dr. Tienie van Rooyen (Practice no. 3601374) to take photographs of me. I understand that these photographs may be of a personal nature. I give doctor van Rooyen and his practice my consent to use these photographs and my personal information (patient information, pathology reports, medical history etc.) and/or supply my medical aid or relevant doctors (including their staff) with any of the above mentioned information. \_\_\_\_\_ (initial).

Please note that all doctors and staff will handle your information with a professional nature.

I, \_\_\_\_\_, hereby confirm that I understand the above disclaimer and that I agree to give my full consent as described above. \_\_\_\_\_ (initial).

Signed at \_\_\_\_\_ on the \_\_\_\_\_ of \_\_\_\_\_ 20\_\_

## VRYWARING

Ek, \_\_\_\_\_, gee hiermee toestemming aan die praktyk van Dr Tienie van Rooyen (Praktyk Nommer. 3601374) om foto's van my te neem. Ek verstaan dat hierdie foto's moontlik van 'n persoonlike natuur mag wees. Ek gee vir Dr. van Rooyen en sy praktyk toestemming om hierdie foto's en my persoonlike inligting (pasiënt inligting, patologiese verslae, mediese geskiedenis) te gebruik en/of te verskaf aan my mediese fonds en/of enige relevante dokters (insluitend hul personeel). \_\_\_\_\_ (parafeer).

LET WEL dat u inligting professioneel sal hanteer word deur die praktyk en die betrokke dokters.

Ek, \_\_\_\_\_, bevestig dus dat ek die bostaande vrywaring verstaan en aanvaar en dat ek volle toestemming aan Dr. van Rooyen en die sy praktyk gee. \_\_\_\_\_ (parafeer).

Geteken by \_\_\_\_\_ op die \_\_\_\_\_ van \_\_\_\_\_ 20\_\_

PR. 3601374

Suite G05, Kloof Hospital, 511 Jochemus Street  
Erasmuskloof x3, 0048

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## KOSMETIESE PASIËNTE

Teater bespreking kan gedoen word met die betaling van **R 1000 – 00.** Hierdie bedrag word verbeur indien u op enige stadium sou kanselleer.

Nadat u 'n kwotasie gekry het (3-5 werks dae) kan u ons kontak om teater te bespreek. Na bespreking sal u 'n epos ontvang wat aandui dat u ons gekontak het en dat u belangstel in 'n spesifieke datum. Sodra ons u bewyse van betaling van die deposito ontvang sal ons die bespreking vas maak.

- Kosmetiese prosedures moet 7 dae voor die operasie datum ten volle betaal wees.
- Kwotaties neem 3-5 werksdae.
- U konsultasie fooi dek u opvolg afspraak.

**PATOLOGIE:** Let asseblief op dat u moontlik 'n rekening vanaf die patoloë mag ontvang. Indien u fonds nie hierdie toetse dek nie is hierdie rekening vir jou eie onkostasies.

## COSMETIC PATIENTS

Theater bookings can be made after a payment of **R1000 – 00.** This amount is not refundable if you cancel at any time.

Once you have received your quotation you can contact us in order to book a theater date. You will receive an email confirming that you have inquired about a specific date. When we receive your proof of payment of the deposit we will confirm your booking.

- Cosmetic procedures must be paid in full at least 7 days before the date of operation.
- Quotations take 3-5 working days.
- Your consultation fee covers your follow-up appointments.

**PATHOLOGY:** Please note that you may receive a bill from the pathologist. If your medical aid does not cover this bill it will be for your own expense.

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Handtekening /Signature

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Datum /Date

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## MEDIESE FONDS PASIËNTE

As gevolg van verskeie probleme met die goedkeuring en betaling van mediese eise, moes die praktyk van Dr M (Tienie) van Rooyen, vanaf 1 Desember 2013 ongelukkig van alle diensooreenkoms met die mediese fondse onttrek. Ons vra nie skema tariewe nie, dus mag u moontlik 'n bybetaling hê.

U moet self by u fonds aansoek doen vir goedkeuring (magtiging). Die praktyk hanteer ongelukkig nie hierdie proses nie. Ons sal aan u 'n motiverings brief stuur met die nodige inligting. Hierdie brief kan 'n week of meer neem.

Om rede ons uitgekonnekteer is, betaal u fonds die geld direk aan u. **Let op dat ons wel in kennis gestel word hiervan.** U het 1 week na die fonds u betaal het om u volle rekening by ons te vereffen. Dit is u verantwoordelikheid om seker te maak dat u die rekening kry. Ons behou die reg om rente te heg aan rekeninge wat meer as 30 dae uitstaande is.

**PATOLOGIE:** Let asseblief op dat u moontlik 'n rekening vanaf die patoloë mag ontvang. Indien u fonds nie hierdie toetse dek nie is hierdie rekening vir jou eie onkoste.

**GEMS:** Weens verskeie probleme wat ons met GEMS ervaar moet alle GEMS pasiënte dokter van Rooyen se rekening ten volle vooraf betaal en die geld by hul fonds eis.

### MAGTIGING VIR FOOIE VERSKAF DEUR HIERDIE PRAKTYK

Ek, \_\_\_\_\_ gee hiermee –

- Toestemming dat die praktyk al my inligting en foto's aan my mediese fonds of ander mediese praktyke (indien nodig) mag deurgee
- Kennis dat ek ingelig is dat hierdie praktyk nie skema tariewe of die tariewe wat die departement van Gesondheid vir dokters voorgeskryf het vra nie. Hierdie tariewe word na verwys as die 'Reference Price List (RPL)'
- Bevestig ek dat "RPL" tariewe vir dienste gelewer beskikbaar is deur die Departement van Gesondheid (Tel 012 312 000) En HSPCSA (Tel no.: 012 338 9300) en [www.doh.gov.za](http://www.doh.gov.za);
- Kennis dat ek aanvaar dat ek ten volle verantwoordelik is vir betaling van dienste gelewer; ek neem ook kennis dat ek verantwoordelik sal wees vir enige wettiglike fooie wat gehag sal word om die uitstaande fooie van my rekening te verkry.

Handtekening /Signature

Datum /Date

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## MEDICAL AID PATIENTS

Due to various problems with the approval and payment of medical claims, the practice of Dr. M (Tienie) van Rooyen unfortunately had to withdraw from its payment agreement with all medical aids as of 1 December 2013. Therefore the full payment of Dr. van Rooyen's account is solely the responsibility of the patient. We do not charge scheme tariffs; therefore you may be subject to a co-payment.

You are required to apply for authorization from your medical aid for your procedure. Unfortunately our practice does not handle this process. We will supply you with the necessary codes in a letter of motivation. This letter may take a week or more to complete.

Because we do not have any agreements with any medical aid schemes, your scheme will pay the money directly into your account. **Please note that we are notified when payment is made to you by your scheme.** Once your scheme has paid you, you are required to settle your full account with Dr. van Rooyen within 1 week. It is your responsibility to make sure that you have received all your accounts. Please note that accounts that are in arrears for more than 30 days are subject to added interest.

**PATHOLOGY:** Please note that you may receive a bill from the pathologist. If your medical aid does not cover this bill it will be for your own expense.

**GEMS:** Due to various problems with Gems, all gems patients are required to settle Dr. van Rooyen's full account and claim it from their medical scheme before we can proceed with the procedure.

### CONSENT TO THE FEES BEING CHARGED BY THIS PRACTICE

I, \_\_\_\_\_ do hereby –

- Acknowledge that I have been informed that this practice does not charge the rates that the Department of Health has unilaterally determined for doctors and which are known as the Reference Price List (RPL);
- Confirm that I am aware that the RPL values for services are available from the Department of Health (Tel no: 012 312 000) and the Health Professions Council of South Africa (Tel no: 012 338 9300) and [www.doh.gov.za](http://www.doh.gov.za);
- Accept that I am fully responsible for payment for services rendered and should I not pay timeously, understand that I will be liable for debt recovery costs of an attorney and own client scale.

Handtekening /Signature

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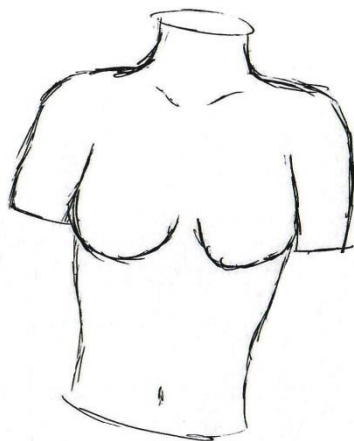
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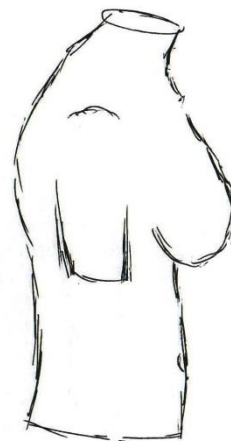
**BASIESE INLIGTING VIR BORS KONSULTASIE / BASIC INFORMATION FOR BREAST CONSULT:**

Gewig / Weight	
Lengte / Height	
Bra grootte / Bra size (If applicable)	
Watter Grootte wil u graag wees? / What is your desired size? (If Applicable)	

**ASSEBLIEF HEG FOTOS AAN VAN DIE VOLGENDE AANGESIGTE VAN DIE GEAFFEKTEERDE AREA /  
PLEASE ATTACH PHOTOGRAPHS OF THE FOLLOWING ANGLES OF AFFECTED AREA:**



FRONT



SIDES

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