MAIN MEMBER AND MINOR DEPENDANT MANAGED HEALTHCARE CONSENT FORM



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Membership	numb	er																									
hereby give Personal In							•		,	•				•				nforr	natio	n, a:	s de	fined	d in	the	Prote	ectio	n of
CHRONIC (CONDI	TION	5																								
Addison's d	lisease	5					C	rohn's	disea	se							Ну	pert	ensio	n							T
Asthma							D	iabete	es insi	pidus							Ну	poth	yroid	ism							
Bipolar mod	od disc	order					D	iabete	es me	litus t	ype 1						Μι	ıltiple	e scle	rosi	S						
Bronchiect	asis						D	iabete	es me	litus t	ype 2						Pa	rkins	on's c	lise	ase						
Cardiomyo	pathy						D	ysrhy	thmia	S							Rh	eum	atoid	arth	nriti	S					
Chronic rei	nal dis	ease					E	pileps	у								Sc	hizop	hreni	ia							
Chronic obstructive pulmonary disease (COPD)							G	Glaucoma											Systemic lupus erythematosus (SLE)								
Cardiac failure								Haemophilia											Ulcerative colitis								
Coronary artery disease								Hyperlipidaemia																			
NON-CDL	CONDI	TION	S																								
Acne - severe							U	Urinary incontinence										Neuropathy									
Attention deficit disorder/ Attention deficit hyperactivity disorder (ADD/ADHD)						D)	Gastro-oesophageal reflux disease (GORD)										Polyarteritis nodosa										
Allergic rhi	nitis						Paget's disease										Scleroderma										
Eczema							Ankylosing spondylitis										Sjogren's disease										
Migraine pr	ophyla	axis					Hypopituitarism										Trigeminal neuralgia										
Gout proph	ylaxis						Osteoarthritis										Psoriatic arthritis										
Major depre	ession						Alzheimer's disease										Blepharospasm										
Obsessive	compu	Isive o	disorde	er			Collagen diseases										Dystonia										
Osteoporos	sis						Dermatomyositis																				
Psoriasis							Motor neuron disease																				
PMBs																											
Aplastic an	aemia						F	Female menopause										Paraplegia/Quadriplegia									
Chronic and	emia						F	brosii	ng alv	eolitis							Po	lycys	tic ov	/aria	an s	yndro	ome	2			
Benign pro	static	hyper	trophy	,			G	raves'	disea	se							Pu	lmon	ary e	mbo	olisn	n					
Cushing's d	lisease	<u> </u>					Н	Hyperthyroidism									St	roke									
Cystic fibro								Hypophyseal adenoma																			
Endometric								Idiopathic trombocytopenic purpura																			
DISEASE N	1ANA	GEME	NT													1											
Back and n	eck ca	re					D	ialysis	care								Ma	tern	ity ca	re							
Oncology c	are							iabete		2																	
HIV/AIDS care								eama	tology	,																	

Wound care

SUPPORT SERVICES

Alcohol and substance abuse care **OTHER (PLEASE SPECIFY)**

Stoma care

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- 1. I confirm that I am aware that the Personal/Special Personal Information includes, but is not limited to my health, medical and treatment records.
- 2. I expressly give informed consent to Bestmed to share the said Personal/Special Personal Information with any Managed Healthcare Provider that Bestmed may appoint from time to time, to manage my condition(s) as indicated above.
- 3. I further expressly give informed consent for Bestmed to obtain my Personal/Special Personal Information from any party who may be in possession of information relating to my state of health, treatment received or expected, as well as any other information that may be in possession of that party which Bestmed may deem relevant for the management of my condition(s).
- 4. I confirm that I am aware of the fact I can revoke my consent for the processing of my Personal/Special Personal Information, at any time by written communication to Bestmed. I also understand that me revoking my consent may result in Bestmed not being able to adequately render medical aid services to me.
- 5. I hereby indemnify and hold Bestmed harmless against any claims of whatever nature that may arise as a result of the processing of my Personal/Special Personal Information.

2. CONSENT ON BEHALF OF MINOR DEPENDANT (CHILD UNDER THE AGE OF 18)

l,																									
Membership	1/4 Membership number																								
in my represe	entativ	е сар	acity	as th	e Spoi	use/Pa	artner	cner/Parent/Guardian/Other (Please specifiy)																	
of																									
ID number																									
hereby give of the Protection																					rmatio	n, as	define	ed in	
CHRONIC C	ONDIT	IONS	5																						
Addison's di		Cı	ohn's	disea	se						Ну	Hypertension													
Asthma							D	abete	s insi	oidus						Ну	pothy	roidis	m						
Bipolar moo		D	abete	s mel	itus t	ype 1					Μι	ıltiple	sclero	osis											
Bronchiecta		D	abete	s mel	itus t	ype 2					Pa	rkinsc	n's di	sease											
Cardiomyop		D	ysrhyt	hmias	5						Rh	Rheumatoid arthritis													
Chronic ren		Eı	oilepsy	/							Sc	Schizophrenia													
Chronic obs		G	aucon	na							Sy	Systemic lupus erythematosus (SLE)													
Cardiac failu		Н	aemop	hilia							Ulo	erativ	ve coli	itis											
Coronary ar	tery di	sease	<u>:</u>				Н	yperlip	oidaer	nia															
NON-CDL C	ONDIT	IONS	5																						
Acne - seve	re						U	rinary	incon	tinend	ce					Ne	uropa	ithy							
Attention de deficit hype						D)		astro- iORD)	oeso	phage	eal ref	lux di	iseas	e		Polyarteritis nodosa									
Allergic rhin	itis						P	aget's	disea	se						Sc	Scleroderma								
Eczema							Α	nkylos	ing sp	ondy	litis					Sjo	Sjogren's disease								
Migraine pro	phyla	xis					Н	ypopit	uitari	sm						Tri	Trigeminal neuralgia								
Gout prophy	/laxis						0	steoar	thriti	S						Psoriatic arthritis									
Major depre	ssion						А	zheim	er's d	isease	5					Blepharospasm									
Obsessive c	ompuls	sive d	isord	er			C	ollagei	n dise	ases						Dy	Dystonia								
Osteoporosi	Osteoporosis																								
Psoriasis							М	otor n	euron	disea	ise														
PMBs																									
Aplastic ana	emia			F	Female menopause									Paraplegia/Quadriplegia											
Chronic ana	emia						Fi	Fibrosing alveolitis									Polycystic ovarian syndrome								
Benign pros	tatic h	ypert	rophy	y			G	Graves' disease									Pulmonary embolism								
Cushing's di	sease						Н	Hyperthyroidism									Stroke								
Cystic fibros	sis						Н	Hypophyseal adenoma																	

Idiopathic trombocytopenic purpura

Endometriosis

DISEASE MANAGEMENT				
Back and neck care	Dialysis care	Maternity care		
Oncology care	Diabetes care			
HIV/AIDS care	Heamatology			
SUPPORT SERVICES				
Alcohol and substance abuse care	Wound care	Stoma care		
OTHER (PLEASE SPECIFY)				

- 1. I confirm that I am aware that the Personal/Special Personal Information includes, but is not limited to the health, medical and treatment records of my Minor Dependant.
- 2. I expressly give informed consent to Bestmed to share the said Personal/Special Personal Information with any Managed Healthcare Provider that Bestmed may appoint from time to time, to manage the condition(s) of my Minor Dependant, as indicated above.
- 3. I further expressly give consent for Bestmed to obtain any Personal/Special Personal Information of my Minor Dependant from any party who may be in possession of information relating to my Minor Dependant's state of health, treatment received or expected, as well as any other information that may be in possession of that party that may be deemed relevant by Bestmed for the management of my Minor Dependant's condition(s).
- 4. I warrant that by giving consent on behalf my Minor Dependant, I do so in my capacity as a competent person in respect of such Personal/Special Personal Information as contemplated in the Protection of Personal Information Act, 4 of 2013.
- 5. I confirm that I am aware of the fact I can revoke my consent for the processing of the Personal/Special Personal Information of my Minor Dependant, at any time by written communication to Bestmed. I also understand that me revoking this consent may result in Bestmed not being able to adequately render medical aid services to my Minor Dependant.
- 6. Accordingly, I hereby indemnify and hold Bestmed harmless against any claims of whatever nature that may arise as a result of the processing of my Minor Dependant's Personal/Special Personal Information.

Signature													
Signed at						on this		day of	month	Υ	Υ	Υ	Υ