PASA
PERFUSIONIST ASSOCIATION OF SOUTH ARICA
PERFMED

Perfusionist's Consent Form

Perfusionist _____ **Account number** _____

Space for the patient's sticker

Introduction to Perfusionists

A cardiovascular perfusionist is a qualified and registered with HPCSA Clinical Technologist who form part of a surgical team. Perfusionists operate extracorporeal (situated or occurring outside the body) circulation, autotransfusion (using the patient's own blood) equipment, and perform a variety of related functions during any medical situation where it is necessary to support or temporarily replace the patient's circulatory or respiratory (breathing) function as well as to manage a blood loss during risky surgical procedures.

Consent for perfusionist's services and Agreement between the Perfmed IPA member who is registered Clinical Technologist, Perfusionist and you the Patient.

1. I confirm that I have been informed regarding the purpose of Perfusionist involvement during the operation.
2. I confirm that the risks and complications generally associated with this procedure have been explained to me.
3. I understand what my options of healthcare are, as explained to me by the surgeon. I understand these options and have consented to the treatment and the procedure (extracorporeal circulation, autotransfusion, IABP, ECMO and etc.).
4. I understand what this healthcare means, and what it will take from me and further that no one can guarantee an incident free outcome. I have been told about the benefits, risks and costs of the healthcare.
5. I understand the risks of the use of procedure/s, as mentioned in point 3 above, and I agree to those risks.
6. I understand that there is equipment and theatre staff supplied by the hospital which cannot be guaranteed by the perfusionist.
7. I understand that I can refuse healthcare at any stage, but also understand that if I refuse, there may be severe consequences of the refusal. I will then not hold any of the Health care

professionals, including perfusionist, 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.

8. I agree to the processing of my health and personal information in order to provide me with proper treatment, care and/or for the administration by the institution or professional practice concerned. This consent would extend to responsible parties acting as service providers to the institution or professional practice concerned.

Payment

1. **<u>This account is completely separate from those of hospital, casualty, surgeon, and any other medical accounts</u>**.
2. The perfusionist charges the fees it regards as appropriate in terms of the experience, services and training of these professionals, as well as the cost-base. Competition law dictates that perfusionists may not agree to charge the same or similar fees.
3. I agree to pay the fee (which may be a multiple or a percentage of the Reference Price List (RPL)) uniquely determined by the perfusionist, estimated at ....., as required by the anti-competitive rules established by the Department of Trade and Industry for the Health Industry.
4. It should be noted that healthcare is not an exact numerical science, and the duration of services, or the number of items used cannot always be exactly estimated. I have been informed of the fees charged 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 the perfusionist will bill for all such healthcare reasonably rendered. Some of the fees are time-based, and if more time is taken to address your healthcare, such extended time will be billed for.
5. Note that unless we have agreed fees with your medical scheme, the fees that we charge, and the benefits awarded by your scheme may not overlap. This would mean that you may be required to pay the difference, or in some cases, depending on the patient's medical scheme, pay for the treatment in full. Should you feel aggrieved by the decisions of your medical scheme, you can approach the: Council for Medical Schemes (CMS) at: *complaints@medicalschemes.com* or fax (012) 431-0608. Note that the CMS would want patients to exhaust internal remedies (appeals in the scheme) first.
6. Should you (the patient, if you are an adult, or the parent of a child-patient) not pay your account within 30 calendar days, we will give you notice of 20 business days where after we will refer your account to an attorney / a debt collecting agency. This will attract additional collection- and other fees. We reserve the right to charge interest of 2% per month on overdue accounts.
7. In deserving cases, we may reduce our fees to accommodate such patients. Patients are encouraged to approach us early on if they experience problems with the payment of the account.
8. I confirm that the nominated postal address is correct for purpose o f receiving the account. I agree that should this address change I will give one week's prior written notice for such change to be effective.
9. I confirm that the particulars furnished by me on all of the pages are in all respects true and complete.

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

_____

Patient / Parent / caregiver / guardian signature