S Buys Pharmacy at SPAR Scriptwise

PATIENT CONSENT FORM

I, _____ hereby acknowledge, give consent and declare by my signature below, that I accept the terms and conditions of this agreement between myself and S Buys (Pty) Ltd trading as Pharmacy at SPAR Scriptwise Courier (hereafter referred to as SCRIPTWISE) Practice Number 0059501.

I hereby give consent and declare:

1. That SCRIPTWISE may access, request, and receive the necessary health and personal information from my health care provider(s) and their staff (hereafter referred to collectively as “health care providers”), to provide me with an authorisation decision from my medical scheme. The information accessed, requested, and received may include information concerning my personal and medical details, amongst other my name(s), surname, date of birth, identity number, medical history, treatment, medical procedures, special investigations as well as any blood and laboratory results if required.
2. I further agree that SCRIPTWISE may interact and liaise directly (by way of e-mail, phone or otherwise), with my medical scheme and my health care providers regarding my Scripts, the use of my medication, the authorisation and specific motivation process for this treatment as well as the monitoring, reporting and follow up of aspects relating to this treatment when necessary for adverse events and patient support programs if applicable to me.
3. I understand that assistance from SCRIPTWISE does not necessarily imply that my medical scheme will provide full/partial/any reimbursement for my treatment. I understand that I will be responsible for the payment of levies, co-payments, or rejections that may be imposed by my medical scheme, and agree that SCRIPTWISE may contact me directly in this regard.
4. I consent and confirm in my capacity as parent/legal guardian of my minor child that SCRIPTWISE may process the special or personal information applicable to my child (*only applicable if the patient is a minor*).

Consent to information recording and storage:

5. I understand that SCRIPTWISE will keep all my information confidential and will only use and share this information with the relevant third party, health care providers, and my medical scheme, insofar as is necessary for authorization and delivery of my treatment. Furthermore, I understand that my dispensing data will be kept/stored for 5 years according to South African Pharmacy Council legislation, where after all my information will be destroyed.
6. I further understand that authorised SCRIPTWISE employees will have access to my personal information which include telephonic recordings and written communication.

Right to withdrawal of consent, security, and destruction:

7. I understand the full extent and meaning of this consent and that I have the right to withdraw this consent at any time.
8. I confirm that I have provided accurate personal information to SCRIPTWISE and acknowledge that it is my responsibility to inform SCRIPTWISE of any changes to my provided information to ensure the accuracy of all my details accessed, requested and received by SCRIPTWISE.
9. I understand that if there is reason for me to believe that my personal information has not been processed professionally or appropriately and/or has been compromised or misused, I may contact the Information Officer/Deputy Information Officer of SCRIPTWISE (contact details are contained in the POPIA & PAIA Manual and are also available on the S Buys website - www.sbuys.co.za).
10. I may further request access to, correction, and/or deletion of my personal information by contacting the Deputy Information Officer (Nadine Grobler). Contact details (e-mail) ngrobler@sbuys.co.za, (fax) 018 786 3705, (physical/postal address) S Buys Pharmacy at Spar Distribution Centre, Corner Kaolin & Radium Streets, Carletonville, 2499.

Power of Attorney (If this section is not applicable, please draw a line through this section)

Kindly complete this section should you wish to nominate another person, other than yourself, who may have access to your information that is held by SCRIPTWISE. Particularly created for your comfort and protection of your personal information.

11. I hereby nominate, constitute and appoint _____ (Full Names and Surname of nominated person) with Identity Number _____ and telephone number _____, to act on my behalf in respect of the following matter(s) detailed below:
    - 11.1. request/query of my SCRIPTWISE profile/account/financial information;
    - 11.2. request/query of delivery of my medication from SCRIPTWISE;
    - 11.3. any further queries/disputes that may arise regarding my profile or account at SCRIPTWISE;
    - 11.4. SCRIPTWISE may contact and share my personal information with the above-nominated person, should I not be available;
    - 11.5. I further confirm that I have received consent from the above-nominated and appointed person, acting on my behalf, to provide his/her full personal information to SCRIPTWISE.

I understand the full extent and meaning of this consent and acknowledge that I have the right to withdraw this consent at any time. I confirm that I have read/ (was read to me) and do hereby accept, the full extent of this consent and all the conditions contained herein. I confirm that I am signing this consent freely and voluntarily without any undue influence. The patient and the Main member confirm that we choose our respective residential addresses as our *domicilium citandi et executandi*. We confirm that we, the main member and/or the patient, are liable for the payment of the account at SCRIPTWISE. **In the case of the patient being a minor, the main member will be held liable**.

Patient Details

Patient Full Name & Surname: _____

Patient Identity Number: _____ Email Address: _____

Contact Number (1): _____ Contact Number (2): _____

DELIVERY Address: _____

RESIDENTIAL Address: _____

EMPLOYMENT Address: _____

Medical Scheme: _____ Medical Scheme Option: _____

Medical Scheme Number: _____ Dependent Code: _____

Main Member Name & Surname: _____

Main Member Identity Number: _____ Contact Number: _____

Residential Address: _____ Email Address: _____

_____ _____

Patient/Guardian Signature Date of Signature

PLEASE SEND COMPLETED CONSENT FORMS TO:
popia@scriptwise.co.za

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