Dr Hina Neurosurgery Inc
Dr. Thembani S. Hina
SPECIALIST NEUROSURGEON, ENDOVASCULAR SUBSPECIALIST
Practice Number: 128 1259

Reception: Admin@drhinaneuro.com
021 441 0567 / 021 441 0568
Suite 204, The Link Building,
Netcare Christiaan Barnard Memorial Hospital,
11 DF Malan Street, Foreshore, Cape Town, 8001

Patient Informed Consent

Operation/procedure/treatment/process, upon myself/my spouse/ my dependent.

Name of patient: _____ Surname: _____

Cranial Procedure:

_____

Spine Procedure: _____

Endovascular Procedure: _____

EMERGENCY CONSENT BY NEXT OF KIN ON BEHALF OF A PATIENT THAT IS MEDICALLY INCAPACITATED (If Applicable).

Full Names of Next of Kin: Contact Details:

_____

*My surgeon has provided me with a **general explanation** of the nature of this operation/ procedure/ treatment/ process and the reasons for the indication based on my particular medical condition.*

My surgeon has also discussed with me the risks and benefits of the operation/ procedure/ treatment/ process. Some of these risks include, but are not limited to the following:

General cranial/Spinal surgical complications: infection, allergic reactions, wound breakdown, nerve and blood vessel injury.
Haematoma, blood loss requiring transfusion, prolonged hospitalization, permanent neurological disability, death.

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Endovascular Complications: Groin hematoma, and limb ischemia, failed access, pseudoaneurysm formation.
Thrombo-embolic – Acute ischemic stroke on table, including large vessel occlusion, medium and small distal vessel occlusion.

Vasospasm, including mechanical vasospasm.

Failed to treat pathology at one setting due to access related issues, or unfavourable anatomy.

Complexity of anatomy and pathology may result in radiation over exposure and precautions are taken to limit dose of exposure – but in some instances this may be exceeded with a risk of skin burn from radiation if focused on one area of the body.

Failure of Hardware, catheter fracture, coil migration.

My surgeon has also explained that I can generally expect the following possible consequences and complications as a natural result of the risk of undergoing intervention (some of which are attendant to an invasive procedure). Although some of these may not occur for this procedure these are the common risks worth re emphasis, including but not limited to, the following:

Specific complications:

_____

_____

_____

_____

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My surgeon has explained **alternatives** to undergoing this operation /treatment/ procedure/ process including alternative operative measures that may be deemed necessary or desirable during the course of this operation/ procedure/treatment/ process, also inclusive of:

Treatment vs Natural history discussion;

Patient signature: _____ Date: _____

1. **Reoperation due to unforeseen complications arising from surgery.**

I furthermore grant consent to the administration of a **general or other anaesthetic** for the purposes of the said operation/ procedure/ treatment/ process or alternative operative procedures. I moreover hereby grant consent to my radiological or diagnostic examination / laboratory tests / hospital services that are medically indicated or that the doctors may prescribe.

Patient signature: _____ Date: _____

Guardian / Next of Kin signature (if applicable): _____ Date: _____

2. **Blood transfusion**

I hereby **consent** to a blood / blood product transfusion to myself / the patient upon the instruction of the said medical practitioner if deemed medically indicated.

Patient Signature: _____ Date: _____

Guardian / Next of Kin signature (if applicable): _____ Date: _____

I acknowledge that I have been informed of my / the patient's health status, the range of diagnostic procedure and treatments generally available to myself / the patient, the benefits, risks, surgical approximate costs and consequences generally associated with each option, my / the patient's right to refuse health services and the implications, risks and obligations of such refusal.

After discussing all the above, the surgeon gave me an opportunity to **ask questions and seek further information regarding the above items.** I believe that I do not require further information at this time, and I am prepared to proceed with the recommended operation/ treatment/ procedure/ process. I believe that my physician has honoured my / the patient's right to make my /the patient's own informed health care decision, **give my consent voluntarily and freely**, and certify that I can give valid consent. I understand that I can revoke this consent at any time up until the time the operation / treatment / procedure / process is started.

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I acknowledge that I / the patient has been informed of all the above in **a language understood** by me / the patient.

I acknowledge that I am informed with respect to all aspects of medical risk related to **pandemics**, most recently **COVID-19**, and specifically the increased risk of complications associated with having surgery. This is especially relevant should I / the patient has been exposed to and/or am currently infected, whether symptomatic or not.

Patient signature: _____ Date: _____

Guardian / Next of Kin signature (if applicable) _____ Date _____

Patient Financial Consent and Accountability Agreement

My surgeon has also explained to me that **other physicians and health care providers** may participate in my care. I therefore extend this authorization to these other physicians and health care providers. Although unlikely, if my physician is not available to perform the above operation / procedure / treatment / process, I understand that this authorization is extended to them. If possible, however, I will be notified of the substitution for rescheduling if needed.

1. Financial Responsibility

I acknowledge and accept full financial responsibility for all services provided to me by Dr Hina. I understand that I am responsible for payment of all applicable charges, including but not limited to co-pays, deductibles, non-covered services, and any outstanding balances.

2. Insurance and Billing

I understand that Dr Hina may submit claims on my behalf to my insurance provider. However, I acknowledge that it is my responsibility to ensure that my insurance covers the services provided. If my insurance denies payment or only partially covers the charges, I am responsible for the remaining balance.

Billing Policy: In-Patient
Contracted:
- Discovery Health Classic (217%)
- Discovery Health Executive Plan (300%)

Non-Contracted/Private:
- GEMS Medical Scheme Rate (300%)
- International Patients GEMS Medical Scheme Rate (600%)

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3. Payment Terms

I agree to pay all due amounts at the time of service, unless other financial arrangements have been made. I also understand that unpaid balances may be subject to late fees and collection proceedings, including referral to a collection agency or legal action.

4. Cancellation and No-Show Policy

I acknowledge that failure to provide timely notice for appointment cancellations may result in additional fees. I understand that missed appointments without notice may be charged at the discretion of the provider.

5. Authorization for Release of Information

I authorize Dr Hina to release my billing and treatment information to my insurance provider(s) or other third parties necessary for claims processing and payment verification.

6. Acknowledgment and Signature

I have read and understand this financial consent and accountability agreement. I acknowledge my financial responsibility and agree to the terms outlined above.

7. **Total Estimated Cost of Treatment for Neurosurgical Treatment and Hospital care.**

Total amount in Rands _____(US$_____)

Guarantee of Payment (GOP): Y/N

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Private/Insurance

GAP Cover Y/N

If Y – Details of Gap Cover

Provider Representative Name: _____

Provider Representative Signature: _____

Date: _____

Patient signature/Next of Kin signature: _____

Date: _____

Guardian / (if applicable) _____ **Date** _____

SIGNED AT _____ **THIS** _____ **DAY OF** _____ **20**

WITNESS 1 _____ **WITNESS 2** _____

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PRE OPERATIVE PLANNING NOTES

Date:

CONFIRMATION OF PATIENT DISCUSSION OF PROCEDURE AND EXPECTATIONS

Clinical:

Imaging:

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Goals of Procedure/Treatment:

Recovery and follow up overview:

ICD 10 & PROCEDURE CODES

ICD 10 CODES

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

NRPL PROCEDURE CODES

_____ _____

_____ _____

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_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

DATE OF PROCEDURE

CRANIAL/SPINAL PROCEDURE **DATE** **THEATRE**

_____

SURGEON: **ASSISTANT(S)**

START TIME

END TIME:

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PROCEDURE DETAILS

POSITION AND POSITIONING

CLOSURE

BLOOD LOSS

DRAINS

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SPECIMENS

IMPLANT DETAILS

KEY FINDINGS

COMPLICATIONS/CHALLENGES

POST OP ORDERS

ENDOVASCULAR

Endovascular Neurointerventional: **Assistant:**

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Procedure:

Access:

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Diagnostic DSA:

Intervention:

Groin Run:

Closure:

Key Findings:

Total Radiation Dose:

Follow up plan:

Disposables/Materials used.

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Access:

Intervention:

Closure:

Post Operative Clinical Review. Date: Time:

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