MAXFACIAL INC.

Co. Reg. No 2002/012483/21

DIRECTOR : **Dr H E C Krüger**
BChD (Stell). MBChB (Stell). FCMFOS(SA)
Maxillofacial and Oral Surgeon

Pr. No. 6201423

PO Box 11195
5213 SOUTHERNWOOD
Tel: 043 - 722 6212
Fax: 043 - 743 3994

36 St James Road
5201 EAST LONDON
Cell: 082 371 5822
E-mail: hkruger@net4u.co.za

Our Reference no: …….. ***Date***: ……..

Patient: ……
Diagnosis: ..……
Indication for Surgery: ..……...
Operation Date: ……
General anaesthesia / Local anaesthesia
St.James Hospital / St.Dominics Hospital / In Surgery

COST ESTIMATION (valid for 30 days, post-surgical visits, excluding x-rays, pro-deo for 3 months): M/O/P

Code(s)	ICD Code	Description/Tooth number(s)	Fee	Total
		……	……	
		……	……	
		……	……	
		……	……	
		……	……	
		……	……	

NB : This practice does not have any contracts with Medical Aid/Insurers. This estimate is as accurate as possible prior to surgery. Due to the nature of the surgery, unexpected complications may unfortunately arise. These are neither expected nor quoted for, and should they occur, it may incur additional costs. The nature of possible complications of surgery have been fully explained to me and I understand the nature and extent of these risks.
Your medical aid/insurance will most likely not settle this amount in full, and it is your responsibility to ascertain what your portion of this account will be.

DEPOSIT REQUIRED BEFORE SURGERY: R_____

DECLARATION BY THE MEMBER/PATIENT/LEGAL GUARDIAN/GUARANTOR:
(Person responsible for payment)
I hereby give my consent for the above operation as explained by Dr Kruger. I understand and accept all the possible complications/risks and have asked questions in this regard. I have also studied the Financial Policy and the Cost Estimation Documents and take full responsibility for settlement of the above account within 60 days.

NAME (printed) : _____ I.D.No : _____

SIGNED : _____ DATE : _____

Relationship to the Patient : _____

Yours sincerely
DR.H.E.C.KRUGER