

Mental Wellness Programme Contract and Consent Form

Membership Number		Date	
Surname			

I, the undersigned understand that Private Health Administrators™ requires access to personal information in order to make recommendations about funding my proposed treatment.

Unless otherwise stated, I hereby authorise Dr. _____ and/or the Hospital Case Manager _____, to provide Private Health Administrators™ with any relevant and appropriate medical information regarding myself as they may require in order to assist and advise me in terms of the Mental Wellness Programme and medical scheme benefits.

I also hereby authorise the PHA Dedicated Professional Nurse to contact my (or my beneficiary's) Medical Practitioner in order to obtain treatment plans and progress reports and any other medical information that may be necessary to approve my application for Chronic Medication benefits and monitor continued Psychiatric treatment.

In the event of treatment for substance abuse, I further understand that should I or my beneficiary refuse to follow the advice of the Psychiatrist or Clinical Psychologist or fail to complete the prescribed programme in full, I will be liable for the full costs of treatment and may be required to refund Pick n Pay Medical Scheme any and all amounts already paid by the Scheme.

I understand that this information will be treated in the strictest confidence and will be made available only to the Medical Advisors of the scheme and the PHA Dedicated Professional Nurse.

Signature of Member _____ **and/or**

Patient (if not the member): _____

SIGNED and DATED at _____ **on this** _____ **day of** _____ **20** _____.