



DR FRANCOIS SWART
NEUROSURGEON

MBChB DA DipPeC M Med
PR No: 0451118
MP No: 0450014

PATIENT CONTRACT

I (Full name) _____, the undersigned acknowledge hereby that the following documentation was presented to me for my perusal on Dr Francois Swart's website at www.drfs.co.za. I also acknowledge that I have read the documentation, that I understand the content thereof and that I agree to the stipulations set out in each document.

I declare specifically that I have read, understood and consent to the information in the following documents and that all the information I provided is true and correct:

- General Terms and Conditions Dr F Swart Inc 2022
- POPI Practice Policy Dr F Swart Inc
- Retention Archiving and Destruction Practice Policy

Signed at _____ on this _____ day of _____ 20_____.

Name: _____

Id number: _____

Signature: _____

