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 2023

◯ POPI Practice Policy Dr F Swart Inc

◯ Retention Archiving and Destruction Practice Policy

Signed at ___________________on this _________ day of _________ 20______.

Name: ______________________

Id number: ______________________

Signature: ______________________

Cintocare Hospital, 175 Frikkie de Beer Street, Room 12 Level 5, Menlyn Maine, Pretoria East, 0181
Tel: 012 945 3028 / 3029 • Fax: 086 500 2065 • Emergency: 012 333 6000 • Email: drFswart@outlook.com • www.drfs.co.za