

CONSENT TO REMAIN IN PRIVATE FACILITY FORM



RMA
Renaissance Health
Medical Aid Fund

Tel: +264 83 2999 000

E-mail queries: confirmation3@prosperitynam.com

Kindly do not use Tippex in the completion of this form - kindly initial where corrections have been made and complete accordingly.

Section A - Patient Details

Surname															
Full Names															
Identity Number/Date of Birth															
Member Number															

Section B - Patient/Guardian/Authorised Representative

Surname															
Full Names															
Identity Number/Date of Birth															
Relation to Patient															

Section C - Health Care Providers

Facility Name														
Facility Representative Name & Surname														
Facility Representative Designation														
Treating Doctor														
Admission Date	D	D	M	M	Y	Y	Y	Y						

Section D - Benefits

Total Annual Benefits (Benefit Category)														
Benefits Utilized to Date														
Estimated Outstanding Claims (N\$)														
Benefits Available														

Section E - Medical Aid Fund Representatives

Representative Name & Surname														
Representative Designation														
Representative Name & Surname														
Representative Designation														

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Section F - Consent To Remain In Private Facility

I, _____ [Name of Patient/Guardian/Authorised Representative], the undersigned, hereby give my informed and voluntary consent for _____ [Patient's Name] to remain at _____ [Private Facility Name] for continued medical treatment, despite the exhaustion of available medical aid benefits.

By consenting to remain in the private facility, I acknowledge and agree to the following:

1. Exemption of Trustees and Medical Aid Fund from Costs:

I understand and agree that the Medical Aid Fund, its trustees, administrators, and associated entities (collectively referred to as "the Fund") shall not be responsible for any further costs, fees, or charges incurred for the treatment of the patient at the private facility beyond the exhaustion of the available medical aid benefits. Any and all costs associated with the continued treatment of me/the patient at the private facility shall be for my own account.

2. Right to Apply for Ex Gratia Assistance:

I acknowledge that while I/the patient has the right to apply for ex gratia assistance from the Fund, such assistance is not guaranteed. The decision to grant ex gratia assistance is entirely at the discretion of the Fund's trustees, and there is no obligation on the part of the Fund to approve any application for additional financial support.

3. Acknowledgement of Financial Responsibility:

I accept full financial responsibility for all costs associated with my/the patient's continued treatment at the private facility. I acknowledge that by choosing to remain at the private facility, I am making an informed decision to incur these costs, and I release the Fund and its trustees from any liability or obligation to cover such expenses.

4. Binding Effect on Heirs and Assigns:

I acknowledge that this consent form and its provisions shall be binding upon me, my heirs, executors, administrators, successors, assigns, and transferees, as well as upon the Patient's heirs, executors, administrators, successors, assigns, and transferees. This binding effect shall apply regardless of any change in the circumstances of the Patient or Guardian/Authorised Representative.

5. Confidentiality:

I understand that all personal and medical information will be treated as confidential, and only shared with relevant healthcare providers and the Fund as necessary to manage the patient's care and financial obligations.

Acknowledgement and Signatures

I, the undersigned, confirm that I have read and fully understood the terms of this consent form. The implications of remaining in the private facility, including the financial responsibilities and the option to apply for ex gratia assistance, have been explained to me in detail. I have had the opportunity to ask questions, all of which have been answered to my satisfaction. I voluntarily consent to remain in the private facility and accept the terms outlined above.

I herewith sign this Consent to Remain in Private Facility Form at a time when I am of sound mind and after careful consideration.

Patient/Guardian/Authorised Representative Name								
Signature								
Date	D	D	M	M	Y	Y	Y	Y

Section G - As Witnesses

Treating Doctor Signature	
Facility Representative Signature	
Medical Aid Fund Representative Signature	