WellMan Clinic

PATIENT CONSENT , INDEMNITY AND WAIVER

1.

1. I.....(patient)

Hereby acknowledge that-

1.1 I have consulted the doctor in relation to the treatment of a particular condition suffered by me.

1.2 The available options for the treatment of my condition, in light of any pre-existing conditions that I may have, together with the benefits , possible risks , side effects, costs and consequences associated with the various forms of treatment , use of medicines and devices prescribed to me are to my satisfaction. I was given the opportunity to ask any questions relating to the possible harm that I may suffer as a result of the treatment including, without limitation, potential risks and side effects of the treatment. I have received satisfactory answers from the doctor in this regard.

1.3 I have given my informe211 OXFORD STREET , SOUTHERNWOOD
TEL: 043 743 2302 /0741 IMPILO (467 456)d consent to the following treatment that the doctor has advised me is necessary for the treatment of my condition.

Condition: Erectile Dysfunction ☐

Premature ejaculation ☐

Low Libido ☐

Other ☐

Treatment: Self injection therapy ☐

Oral therapy ☐

Other ☐

2. In so far as I have decided to purchase and use the following medicine/s and medical device/s prescribed to me by the doctor, I acknowledge and agree that –

2.1 all vials and syringes forming part of the medication are sterile at the time that they are provided to me and that the continued sterility of these items is my responsibility

2.2 I must use and consume the medication in accordance with the directions and instructions given to me by the health care professional and in terms of the patient information leaflet and instructions for use of the relevant medication.

2.3 I understand and am aware of the possible side effects and risks associated with consuming and using the medication in contravention of any instructions for the use of the relevant medication;

2.4 If I do not use the medication in accordance with the directions given to me by the doctor/ dispensing assistant or as set out in the patient information leaflet, any physical damage that is caused to any of my property or such failure by me gives rise to any death, injury , illness, loss or any economic loss to me or any of my dependants , or to any other person who may , whether authorised to or not , also consume or use the medication, then I shall not hold the clinic , the doctor or dispensing assistant or employees liable for such death , injury, illness. Loss or physical damage to any property or for economic loss

The Medicine/s

Quad Mix (Papaverine/Chlopromazine/Atropine/PGE1)

Cialis Levitra Sildenafil

Fluoxetine Anafranil Other.....

Auto injector

3. WAIVER AND INDEMNITY

Except to the extent that the doctor acts with gross negligence or fraudulent intent in respect of treatment;

3.1 I hereby waive all claims of whatsoever nature and howsoever arising which I may have against the clinic or staff thereof, n connection with or related to the treatment, including , without limiting the generality of the foregoing claims arising out of any direct/indirect effects which I may suffer as a result of the treatment or any medication that may be prescribed to me and/or as a result of my failure to follow the instructions given to me by the doctor concerning the treatment and my health.

3.2 I agree to indemnify the clinic and/or any representatives of the clinic and to hold them harmless against any claim which may be instituted by any third party from any cause arising out of the treatment, including , without limitation any claim instituted by my dependants

4. I hereby irrevocably give my express and informed consent that the clinic and any of the health care professional may have access to and use all confidential , medical, personal, financial and other information in connection with the treatment and my health to the extent that;

4.1 This use and disclosure of the information is necessary for any purpose within the ordinary course and scope of the duties of the doctor and

4.2 It may be necessary to ensure continuity in the treatment as well as related administrative and support services to me as a patient of the clinic.

5. I acknowledge and agree that:

5.1 All clinic notes, reports and patient files in connection with the treatment are and will remain the property of the clinic

5.2 The particular health care professional with whom I initially consult may not be available at all times to treat me.

5.3 in the event of the non-availability of any health care professional who attended to me at the clinic, the clinic may arrange for my treatment to be continued by a different doctor who shall be entitled to have access to and examine the health records.

5.4 I will provide accurate information about my health status and medical history to the clinic.

5.5 If an erection lasts longer than four hours, I must contact the doctor with whom I consulted or present myself to a hospital if the doctor cannot be reached. I understand that this health care professional may not be available at all times and that the clinic may not be held liable for any payment made by or on behalf of me to the hospital.

5.6 My failure to comply with any instructions by any of the health care professionals may give rise to complications in respect of the treatment and may adversely affect my health .The health care professional shall not be held liable for this or any other consequence arising directly/indirectly from this failure by me.

6. I have had an opportunity to receive and read and I fully comprehend the terms, conditions and consequences of this consent form.

I have: 6.1 been made aware of all the terms printed here

6.2 had sufficient opportunity to ask questions about this consent form and have had these questions, if any, answered to my satisfaction.

7. My consent to the terms of this form is provided of my own free will without any undue influence from any person whatsoever. I have also been provided with a copy of this signed consent form by the clinic.

8. My signature below indicates my understanding of an agreement to comply with the terms of this consent form.

Signed patient:.....

Date : .....

Name in block letters: .....

I confirm that I have fully explained to the patient the nature and purpose of the treatment and he has given me informed consent to the performance of the treatment

Signed doctor:.....Date: .....

Name of Doctor: .....