IMPROVED CLINICAL PATHWAY SERVICES

REGISTRATION NUMBER: 2011/106866/07
VAT NUMBER: 4690265345
MCO ACCREDITATION NUMBER: 107

# ICPS Patient Consent Form – Cataract Surgery

***Please read this form carefully and sign at the bottom. If you have any further questions, please do not hesitate to ask. You have the right to change your mind at any time, including after you have signed this form.***

## 1. CONSENT TO CATARACT SURGERY AND PAYMENT UNDER THE ICPS PATHWAY

1.1. I hereby consent to undergo cataract surgery of the (please fill in whether left or right)

_____ eye according to the ICPS Pathway.

1.2. ICPS (Improved Clinical Pathway Services) is a registered Managed Care Organisation licenced by the Council of Medical Schemes that managers the clinical pathway under which my treatment will be performed, and payment is handled.

1.3. I understand that: The treating doctors will use the latest science and internationally agreed-upon best practices for cataract surgery.

1.4. I understand that I will be discharged from the hospital or clinic as soon as I am well enough, usually an hour or two after the after surgery.

1.5. I understand that my treating surgeon and anaesthetist will discuss the surgical, medical, and anaesthetic risks relevant to me before my operation.

1.6. 1.6 I understand that ICPS will only pay for uncomplicated cataract surgery. My medical aid will pay for the treatment of complications and may require me to make co-payments.

1.7. I understand that if my medical aid cataract limit is spent before my cataract surgery, my surgery may be cancelled. It is my responsibility to make sure my benefit is not spent.

## 2. CONSENT IN TERMS OF THE PROTECTION OF PERSONAL INFORMATION ACT 4 OF 2013 (POPI ACT)

2.1 Purpose and Consequences:

2.1.1 My personal information, including confidential medical information held by my treating healthcare providers and my treating hospital, will be collected and shared:

- for purposes of my treatment under the ICPS Pathway, the payment therefor, and facilitating quality control
- for certain information to be stored on ICPS's clinical registry and used for research purposes; and
- to enable my medical scheme to access my information as required under the Medical Schemes Act

2.1.2 I may revoke my consent for information to be collected from me or shared with any specific recipient in clause 2.2.1 at any time by notifying ICPS.

2.1.3 I understand that if I do not consent to collecting and sharing my personal information or revoking my consent, I will not be able to undergo treatment under the ICPS Pathway.

2.2 Recipients:

2.2.1 My personal information, including medical information, will be shared among my treating healthcare providers and their practice staff, my medical scheme and its administrator, my treating hospital, and authorised staff at ICPS. In due course, my personal information on ICPS's clinical registry may be shared with researchers.

2.2.2 When my personal information is under the control of ICPS, ICPS is responsible for its security and will comply with the relevant data protection laws. ICPS is not responsible for the security of my personal information when it is under the control of any of the other recipients in clause 2.2.1.

2.3 Storage and Retention:

2.3.1 ICPS will store my personal information in a secure cloud-based storage facility that meets the security requirements for POPI and international data protection laws.

2.3.2 ICPS will take all reasonable steps to protect my personal information and maintain its confidentiality. However, ICPS cannot guarantee the security or integrity of any information I may transmit to ICPS online, and I agree to do this at my own risk.

2.3.3 ICPS will retain my personal information within the statutory limits.

2.3.4 I have the right to access the information being stored by ICPS.

2.3.5 I have the right to complain to the Information Regulator about how my personal information is collected, processed, and stored.

I hereby consent to undergo Cataract Surgery under the ICPS Pathway, its payment terms, and the collection, processing, sharing, and storage of my personal information and confidential medical information, according to the POPI Act and all terms and conditions on this form.

Print Name of Patient: _____

Signature of Patient: _____

Date: _____

***Statement of an interpreter, if necessary***:

I have interpreted the information above to the patient to the best of my ability in their language of choice, being _____ (please complete) and in a way that I believe he/she understands.

Print Name of Interpreter: _____

Signature of Interpreter: _____

Date: _____