



Patient Information:

Surname		Full Names	
Title		Given Name	
Occupation		ID Number	
Tel (Home)		Home Language	
Email Address		Cellphone Nr	
Home Address			

Person responsible for the account/Main member details:

Surname		Full Names	
Title		ID Number	
Physical Address			
Email Address		Tel (Home)	
Tel (Work)		Cellphone Nr	
Employer		Work Address	

Medical Aid Details

Medical Aid Name		Plan	
Medical Aid Number		Dependent Code	

Family Information:

Name	ID Number	Telephone number

Next of Kin:

Name & Surname		Relationship	
Address		Cellphone Nr	
		Email address	

Other information:

Referred by			
GP		Telephone Nr	
Relevant medical information			

I hereby declare that all information given above is correct, I will notify the practice of any changes.

Signed Patient/Guardian

Full names

Date



INFORMED CONSENT:

I _____ the undersigned understand and declare that:

1. CONSENT TO PHYSIOTHERAPY TREATMENT

- During the treatment and evaluation, I may need to uncover specific body parts, and I may refuse to do so if I feel uncomfortable.
- The physiotherapist will need to touch me to provide effective treatment, and I will inform the physiotherapist if I am uncomfortable or feel offended in any way.
- It is my right to withdraw this consent at any time or for any specific procedure or modality.
- I may ask about the treatment modalities, and the benefits and risks will be discussed with me as applicable.
- I understand that the physiotherapist will use the most suited treatment techniques, if there are potential complications or side effects, it will be discussed.
- I have the right to ask questions about my treatment and chosen modalities.
- I hereby consent to physiotherapy procedures and modalities that will be performed on me/my dependent: subjected to the physiotherapist performing the relevant safety tests and evaluation and taking relevant precautions.
- I give this consent freely and declare that it was not made under duress.

2. CONSENT TO FINANCIAL RESPONSIBILITY OF PHYSIOTHERAPY ACCOUNT.

- I hereby **accept full financial responsibility for this account until it is settled in full.**
- I understand that I will be responsible for all legal fees involved, if legal action is needed to collect any outstanding fees.
- I hereby declare all personal and financial information as true and correct.
- Unkept appointments will be billed if not cancelled within 4 hours before the treatment.
- Billing is done according to the NPRL structure.
- No cheques accepted. Patients may pay with cash, credit/debit cards and if arranged with management, by electronic transfer.

3. CONSENT TO THE RELEASE OF INFORMATION

- I hereby give consent to the consulting physiotherapist to disclose information regarding my diagnosis (ICD 10 Coding), medical condition, prognosis, treatment compliance and treatment program to the following people/institutions for the purpose of reimbursement or settlement of his/her account and or for referral and reporting purposes:
- Please tick the boxes that you do give consent to (as applicable):

Medical Scheme/ Funder		Spouse		Employer	
Referring Doctor		School or Coach		Lawyer	
Other medical practitioners		Children/Parents		Insurance company	

I fully understand that this is a legal requirement and that I have a choice not to consent to such information being disclosed to any party. I confirm that I have exercised my choice voluntarily and that this declaration and exercise of my choices was not made under duress.

All patient information is stored and processed according to the POPIA of South Africa.

- I indemnify my treating physiotherapist from any liability, damages or whatsoever that I may suffer as a result of this disclosure or treatment and that I will hold the treating Physiotherapist harmless of any further disclosures and prejudice I may suffer because of. I declare that this consent was not made under duress.

Signed: _____ **Date:** _____