Nommer Number

1 PASIËNT BESONDERHEDE
PATIENT DETAILS

Van Surname	Voornaam First Name		Mnr/Mev/Mej Mr/Mrs/Miss
Geboortedatum Date of Birth	I.D. Nommer I.D. Number		
Beroep Occupation	Huistaal Home Language	Huwelikstatus Marital Status	
Tel. (H)	Tel. (W)	Sel Nommer Cell Number	
E-Posadres E-Mail Address			

2 PERSOON VERANTWOORDELIK VIR REKENING
PERSON RESPONSIBLE FOR ACCOUNT

Van Surname	Voornaam First Name		Mnr/Mev/Mej Mr/Mrs/Miss
I.D. Nommer I.D. Number	E-Posadres E-Mail Address		
Posadres Postal Address			Kode Code
Woonadres Residential Address			Kode Code
Tel. (H)	Tel. (W)	Sel Nommer Cell Number	
Werkgewer Employer	Werksadres Work Address		Kode Code

3 MEDIESE FONDS
MEDICAL AID

Naam Name	Nommer Number
Plan / Opsie Plan / Option	Afhanklikes Dependants
Hooflid se Naam Member's Name	Hooflid se I.D. Nommer Main Member's I.D. Number

4 NAASTE FAMILIE
NEXT OF KIN

Naam Name	Verwantskap Relationship	
Adres Address		
Tel. (H)	Tel. (W)	Sel Nommer Cell Number
E-Posadres E-Mail Address		

5 VERWYS DEUR
REFERRED BY

Naam Name		
Adres Address		Kode Code
Tel. (W)	Sel Nommer Cell Number	
E-Posadres E-Mail Address		

6 FAMILIE LEDE
FAMILY MEMBERS

Name Names	Geboortedatum Date of Birth	Allergieë Allergies	Ander Other

Terms and Conditions

1. CONSENT TO TREATMENT

I hereby, voluntarily give consent, to physiotherapy procedures (incl. Dry needling) and modalities that will be performed on me or my dependent, subjected to the physiotherapist performing the relevant safety tests and evaluation, taking the necessary precautions and explaining the benefits and risks, as well as alternative procedures and modalities. I understand that during the treatment and evaluation I might need to uncover specific body areas and that I may choose not to do so if and when I feel uncomfortable.

_____
Initials

CONSENT TO TREATMENT FOR CHILDREN UNDER THE AGE OF 18

(Only to be signed by the guardian/parent if the patient is under the age of 18 years)

_____
Initials

2. CONSENT TO THE RELEASE OF INFORMATION

I hereby give consent to **Aldelize van Tonder Physiotherapists** to disclose information regarding my diagnosis, medical condition, prognosis and treatment program for account rendering purposes and appropriate referral. Any other information released will be discussed with the signatory according to the POPI Act (Act nr 4 of 2013).

_____
Initials

3. CANCELLATION POLICY

The Practice has a **2 Hour** Cancellation policy. Appointments not cancelled within this time will be charged **R200.00**. The medical aid is not liable for payment, the patient is. **No new appointments** will be booked if this **outstanding amount is not paid** in full.

_____
Initials

4. PAYMENT OF ACCOUNTS

Please note: We use the SASP (South African Society of Physiotherapy) coding structure. This is accepted by most medical aids but it is your responsibility to pay for any codes that are not covered by your medical aid.

Medical Aid Patients: Your account will be submitted to the medical aid electronically, but you as the patient will be liable for any outstanding amount that has not been paid by 30 days. Our contract is with **YOU** the patient **and NOT** the medical aid.

Private Patients: Must settle amount after treatment, or arrangement to be made with the practice owner. If the account is not settled within 30 days of last treatment date the account will be handed over for collection. **Methods of payment** include cash, EFT, Debit and Credit Cards. We regret no Diners or American Express.

ofees.

_____
Initials

Signature: _____ **Date:** _____

Medical Information

Tick √ if relevant

Diabetes		Pacemaker	
High / Low Blood Pressure		Metal Implants	
Previous Cancer		Hormone Therapy	
Hepatitis		Asthma	
Osteoporosis		Pregnant	
Epilepsy		Active Tuberculosis	
Aids / HIV		Acute Venous Disease	
Hiatus Hernia		Infectious Skin Disease	
Contagious Diseases		Heart Disorder: Arrhythmia Insufficiency, Decompensated cardiac edema	

Are you currently seeing a Biokineticist, Chiropractor or another Physiotherapist?

_____
_____

Do you have any other chronic illness?

_____
_____
_____
_____

Any chronic medication?

_____
_____
_____
_____

Signature: _____ **Date:** _____