Lené van der Linde
PHYSIOTHERAPY
www.lenephysio.co.za

balance within freedom

1. Patient information: **Date: __/___/______**

Title: _____________ Initials: _____________ Surname: ____________________________________

First Names: ___________________________________ Marital status: Single / Mar / Div / Sep / Wid

ID No: ____________________________ Passport No (if not SA resident):______________________

Date of birth (D/M/Y): ____________________________ Age: ________________ Sex: F / M ______

Occupation: _________________________ Employer: _____________________________________

Residential address: ____Code:______

Postal address: ____Code:______

E-mail address: ____

Contact no 1: ________________________ Contact no 2: ___________________________________

Referring Doctor: ____________________ How did you find us: Internet / Signage / Friend / Family

2. Person Responsible for Payment of Account (IF DIFFERENT FROM ABOVE)

Please note that patients will be responsible to settle the account and thereafter claim the expenses from the medical aid.

Title: _____________ Initials: ______________ Surname: ___________________________________

First Names: ____

ID No: ______________________________ Date of birth (D/M/Y): ___________________________

Occupation: _________________________ Employer: _____________________________________

Residential address: ____Code:_____

Postal address: ____Code:_____

E-mail: ______________________________ Contact No: ___________________________________

3. Medical Aid

Name of medical aid: ________________________ Number: ________________________________

Initial and surname of main member: ____

ID number of main member: _______________________ Dependant code: ____________________

Patient's relationship to main member: Self / Spouse / Child / Other

(Please turn page)

Lené van der Linde 072 694 4971 BSc Physiotherapy
Cnr of R44 & Klein Helderbergpad Rd, Somerset West, 7130.
Practice No.: 0720000618209

4. In Case of Emergency

Name of local friend or relative (not living at the same address): ______________________________

Relationship to patient: ____________________________ Contact No: __________________________

5. Terms and Conditions

CONSENT TO TREATMENT

I hereby, voluntarily give consent, to physiotherapy procedures and modalities that will be performed on me or my dependant, 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.

CONSENT TO THE RELEASE OF INFORMATION

I hereby give consent to Lené van der Linde Physiotherapy to disclose information regarding my diagnosis (ICD 10 Coding), 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).

COMPLAINTS POLICY & CANCELLATION OF BOOKINGS

At Lené van der Linde Physiotherapy, open communication with regards to feedback, suggestions and complaints are encouraged. I hereby adhere to the policy to manage and discuss matters or complaints within the practice and involved staff members prior to any discussing with an external body or individual.

The practice has a 3 hour cancellation policy. Appointments not cancelled within this time will be charged in full.

PAYMENT OF ACCOUNTS

Patients are responsible for their accounts and for claims from medical aids. Accounts should please be settled within 30 days, thereafter interest of 15% per month will be charged.

Thank you for your agreement. We look forward to our journey with you and hope to assist you to the best of our abilities.

SIGNED at _______________________________ on this _____ day of __________________ 20 _____

Physiotherapist: __________________________ Signature: ________________________________

Patient: _________________________________ Signature: ________________________________