NICKY AKERMANN

PHYSIOTHERAPY

PR 0720007211082

Registered Physiotherapists

Patient Information:

Title: _____ Names: _____

Surname: _____

ID number: _____

Occupation: _____

Work Tel: _____ Home Tel: _____ Cell: _____

Email address: _____

Postal/Residential address: _____

Postal Code: _____

Referring Doctor: _____

Contact Person:

Name: _____ Cell: _____ Work Tel: _____

Person Responsible For Payment Of Your Account:

(Please only complete this if it will not be yourself)

Names and Surname: _____

ID number: _____

Email: _____

Tel. Work: _____ Home Tel: _____ Cell: _____

Please tick: Private Patient ☐ Medical Aid ☐

Medical Aid:

Please note: Hospital Plans do NOT cover Physio unless pre-authorised. Please advise us if this is the case.

** PLEASE COMPLETE THIS SECTION FULLY AND ACCURATELY*

Provider: _____ Membership number: _____

Main Member's full Name and Surname: _____

Dependent code (if not main member): _____

I hereby acknowledge and confirm the above to be true and correct.

Signature: _____ Date: _____

Parent / Legal Guardian (If Patient is a Minor): _____

Informed Consent:

Treatment:

I, the undersigned, hereby confirm that I consent to my treatment as discussed with me by the physiotherapist.

Account Payments:

Medical Aids:

EDI submission directly to your medical aid is a complimentary service we offer. We charge according to your Medical Aid's rate. If your medical aid rejects your claim or does not settle your account, you are responsible to settle on receipt of statement.

Private Patients:

You can settle after each treatment with Credit Card, Snap Scan or cash.

Please Note:

- If you can't keep your appointment, please notify us telephonically at least 2 hours in advance.
- If you do not cancel in due time, a non-arrival fee will be charged to you personally and not submitted to your medical aid.
- 2% interest will be charged monthly on accounts which are 30days overdue.
- From 60 days accounts are handed over to debt collectors.
- You will be liable for administration costs as well as costs incurred in the event of any legal proceedings.

I have read, fully understand and agree to abide by the policies of this practice as clearly stated above

Signed on this day _____ of _____ 20 (year)

Signature: _____

Name: _____

Parent / Guardian (if patient is a Minor): _____