Nicolise Goosen | BSc Physiotherapy (US)
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NICOLISE GOOSEN
PHYSIOTHERAPY
Pr no: 0953334

PATIENT INFORMATION

Please complete the following form in full

FIRST NAMES				**TITLE (MR/MRS/DR, ETC)**	
SURNAME					
DATE OF BIRTH		**ID NUMBER**			
RESIDENTIAL ADDRESS					
				POSTAL CODE	
CELL NO		**EMAIL**			

MEDICAL AID INFORMATION

NAME OF SCHEME		**OPTION NAME**	
MEMBERSHIP NO.		**DEP CODE**	

MAIN MEMBER/PERSON RESPONSIBLE FOR ACCOUNT

(To be completed when main member & patient is not the same person)

FIRST NAMES				**TITLE (MR/MRS/DR, ETC)**	
SURNAME					
DATE OF BIRTH		**ID NUMBER**			
RESIDENTIAL ADDRESS					
				POSTAL CODE	
CELL NO		**EMAIL**			

1. I confirm that the information furnished by me above, is true and correct, and I further submit that the abovementioned address, contact number and email address is my chosen *domicile* addresses for the purpose of service of any invoices, statements, notices and / or legal documents.
2. I submit that the information supplied by me herein, is my latest personal information and that personal information supplied by me on a previous occasion to this practice, is hereby updated and thus no longer relevant.
3. I further confirm that I understand that it remains my responsibility to inform the practice in the event that any of my personal information changes.
4. I confirm that I (the patient) remain personally responsible for any short payment of my account by my medical scheme and / or the main member of the medical aid on the basis that the medical services were rendered to me personally, or my minor child.
5. I confirm that I acknowledge that all accounts in respect of the services rendered to me are due and payable within 30 (thirty) days from date upon which the service was rendered to me and that the information supplied by me will be used to communicate said account(s) to me.
6. I confirm that I accept that interest will be levied on amounts outstanding for more than 30 days from date of statement at today's prescribed interest rate in terms of the Prescribed Rates of Interest Act 55 of 1975.
7. Should legal costs be incurred by the practice as a result of my non-payment, I acknowledge that these are for my account, at attorney and client rate. Should it become necessary to institute legal proceedings against me for recovery of any amount due, I agree to pay all costs on the scale as between attorney and client, including tracing fees and collection commission + VAT thereon.
8. I understand that the details supplied by me, on this form are protected in terms of the POPI legislation. My physiotherapist may however use any of the details provided on this form to pursue payment by me for unpaid accounts.
9. I also understand that my physiotherapist may share and / or refer the details supplied by me as well as my patient records to other medical professionals in the course of the medical treatment required for my treatment, and / or any other party with whom the physiotherapist has a contractual agreement to do so.
10. I authorize my physiotherapist to access my medical aid with my personal medical details.
11. Consultations and additional services will be claimed directly from your medical aid straight after consultation and co-payment must be paid directly.
12. **A 50% consultation fee will be charged for bookings not cancelled three (3) hours before the confirmed booking time slot and appointment/s not kept.**

SIGNED: _____ DATE: _____