ALISON THOMSON
PHYSIOTHERAPISTS

PRACTICE NO. 7240031

PATIENT DETAILS:

SURNAME _____ DATE OF BIRTH _____

FULL FIRST NAME/S_____ MR/ MRS/ MISS

IDENTITY NO._____

EMAIL ADDRESS: _____

LEGAL STATUS: MARRIED_____ DIVORCED_____ SINGLE_____ COHABITING_____

POSTAL ADDRESS_____

_____ CODE_____

HOME ADDRESS _____

_____CODE_____

TEL. NO.: (W) _____ (H) _____

(CELL)_____

BUSINESS NAME AND ADDRESS _____

_____ CODE _____

MEDICAL AID DETAILS AND PERSON RESPONSIBLE FOR ACCOUNT:

MEDICAL AID NAME _____ NUMBER _____

% PAID BY M/A _____% DEPENDANT CODE _____

MAIN MEMBER'S FULL NAME _____**MR/MRS/MISS**

MAIN MEMBER'S IDENTITY NO: _____

EMAIL ADDRESS: _____

CELL NO: _____

MEMBER'S POSTAL ADDRESS (if different to patient's) _____

_____ **TEL NO:** _____

GENERAL PRACTITIONER _____ SPECIALIST: _____

Tel: 021 552 6707 • **www.centurycityphysio.co.za** • **Email:** alijt@mweb.co.za
147 Millennium Business Park, Edison Way, Century City • P O Box 957, Milnerton 7435
The Gym @ Old Mutual, Mutual Park, Jan Smuts Drive, Pinelands 7405
Intercare, Central Park on Park Lane, Century City 7441

Please See Overleaf

ARE ANY OF THE FOLLOWING APPLICABLE TO YOU (please tick):

PREGNANCY		DIABETES		TB	
OSTEOPOROSIS		HEPATITIS		HIGH BLOOD PRESSURE	
PACEMAKER		ASTHMA		AIDS OR HIV POSITIVE	
STEEL IMPLANT		CHOLESTEROL		EPILEPSY	
HEART PROBLEMS		SURGERY FOR CANCER		CONTAGIOUS DISEASES	

ANY OTHER RELEVANT ILLNESSES / PROBLEMS?

ARE YOU UNDER DEBT REVIEW: YES____NO____

I UNDERSTAND AND WHERE APPLICABLE, CONSENT TO THE FOLLOWING:

- MEMBERSHIP OF A MEDICAL AID OR OTHER MEDICAL INSURANCE IS A PERSONAL CONTRACT BETWEEN THE MEMBER AND THAT COMPANY. THIS PRACTICE WILL SUBMIT ACCOUNTS DIRECTLY TO THE MEDICAL AID WHERE POSSIBLE, **BUT I UNDERSTAND THAT ULTIMATE RESPONSIBILITY FOR SETTLEMENT IS STILL MINE.**

- SHOULD MY ACCOUNT BECOME OVERDUE, INTEREST WILL BE CHARGED UNLESS DISCUSSED WITH THE PHYSIOTHERAPIST. LEGAL STEPS CAN BE TAKEN AND ANY COSTS INCURRED ARE FOR MY ACCOUNT.

- **APPOINTMENTS NOT CANCELLED AT LEAST TWO HOURS IN ADVANCE WILL BE BILLED AT THE FULL TARIFF.**

- MY TREATMENT MAY INCLUDE PHYSICAL ACTIVITY. ALL EXERCISE TESTING AND PHYSICAL ACTIVITY SESSIONS WILL BE SUPERVISED AND MONITORED BY A QUALIFIED PHYSIOTHERAPIST. THERE ARE INHERENT RISKS ASSOCIATED WITH PHYSICAL ACTIVITY AND I RECOGNISE THAT IT IS MY RESPONSIBILITY TO PROVIDE ACCURATE AND COMPLETE MEDICAL AND HEALTH HISTORY.
  IT IS MY RESPONSIBILITY TO INFORM THE PHYSIOTHERAPIST IF I DO NOT FEEL WELL DURING TREATMENT OR ACTIVITIES.

- THE PHYSIOTHERAPISTS MAY NEED TO DIVULGE CERTAIN PERSONAL AND MEDICAL INFORMATION REGARDING THE PATIENT TO OTHER ATTENDING PRACTITIONERS AND ADMINISTRATIVE STAFF CONCERNED FOR PURPOSES EITHER RELATING TO THE TREATMENT OR TO PROCESS FOR STATISTICAL, EPIDEMIOLOGY, MANAGED HEALTH CARE AND PAYMENT PURPOSES, WHICH INCLUDES THE SENDING OF THE ACCOUNT TO THE RELEVANT THIRD PARTY PAYER IF APPLICABLE. THESE PRACTITIONERS AND ADMINISTRATIVE STAFF WILL HAVE ACCESS TO THE PERSONAL MEDICAL RECORDS ON A "NEED TO KNOW" BASIS.

- IN ORDER TO PERFORM CERTAIN TREATMENTS**, THE PHYSIOTHERAPIST MAY NEED TO UNCOVER SPECIFIC PARTS OF THE PATIENT'S BODY AND MAKE PHYSICAL CONTACT WITH HIM/HER**. THIS WILL AT ALL TIMES BE CARRIED OUT IN A PROFESSIONAL MANNER, PROTECTING THE PRIVACY OF THE PATIENT AS FAR AS POSSIBLE.

SIGNATURE: _____ **DATE_____**

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