Danielle Labuschagne
PHYSIOTHERAPY

PATIENT HISTORY FORM

1 | PATIENT INFORMATION

Date: __/___/______ Title: ____________ Initials: ____________

Surname: __________________________________ First Names: _________________________________

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: ____

Medical Aid Plan: ______________________ Number: ____________________________________

Initial and surname of main member: ____

ID number of main member: _____________________ Dependant code: ______________________

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

4 | IN CASE OF EMERGENCY

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

Relationship to patient: __________________________ Contact No: ________________________

5 | TERMS + 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 feeluncomfortable.

CONSENT TO THE RELEASE OF INFORMATION

I hereby give consent to Danielle Labuschagne 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 Danielle Labuschagne 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 2 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.

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: ______________________________

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