Marissa Fourie
Physiotherapy

PATIENT

SURNAME	_____	FULL NAMES	_____
GIVEN NAME	_____	OCCUPATION	_____
DATE OF BIRTH	_____	ID NUMBER	_____
TELEPHONE (H)	_____	TELEPHONE (W)	_____
CELLPHONE	_____	EMAIL	_____

PERSON RESPONSIBLE FOR ACCOUNT

SURNAME	_____	FULL NAMES	_____
DATE OF BIRTH	_____	ID NUMBER	_____
CELLPHONE	_____	EMAIL	_____
HOME ADDRESS	_____	POSTAL ADDRESS	_____
	_____		_____
	_____		_____

NEXT OF KIN

NAME AND SURNAME _____ CONTACT NUMBER _____

PLEASE TICK THE RELEVANT OPTION:

Please send my account directly to the medical aid. I undertake to settle any outstanding amount that they may not cover. ☐

I prefer to pay by card after consultation. An invoice will be sent electronically. ☐

MEDICAL AID INFORMATION

MEDICAL AID	_____	PLAN	_____
MAIN MEMBER	_____	MAIN MEMBER ID	_____
MEMBER NUMBER	_____	PATIENT CODE	_____

I, _____ (name in print) **have read and agree to the patient agreement printed on the back of this document.**

Signature: _____ Date: _____

PLEASE NOTE: The arrangement of pre-authorisation if required by your medical aid remains the responsibility of the patient and <u>not</u> of the practice.

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PATIENT AGREEMENT:

1. I confirm that the information on my file is correct and agree to notify any change within 14 days and to supply new data accordingly.
2. I give consent that Marissa Fourie Physiotherapy may claim the relevant billing codes as used in treatment, directly from my medical aid. I take full responsibility for the account and to pay all money not paid by my medical aid, within 90 days after receipt of my account.
3. Private accounts are payable directly after consultation. This practice accepts credit/debit cards, or an EFT can be done on arrangement.
4. I accept that in the event of my noncompliance with any of the above, my account may be handed over to an attorney/debt collectors and I will be liable for all legal costs, including collection commission and trading fees.
5. I consent to sharing of all relevant ICD10 codes with my medical aid/insurance (if applicable) as well as any other medical practitioners who may form part of my treatment team.
6. I hereby take note that the physiotherapist may request me to partially undress as necessary for proper evaluation and/or treatment.
7. I give permission for the physiotherapist to use electrical modalities/apparatus on me during treatment sessions and for her/him to use the appropriate treatment methods she recommends for my specific condition/problem.
8. I take note that any personal information gathered by the Practice of myself/my child will be treated in accordance with the POPIA as set out in the Practice Privacy Policy, which is available on www.mfouriephysio.co.za. A hard copy is available on request.
9. Should I not arrive for my appointment without prior cancellation, I may be held accountable for a fee equivalent in value to a standard treatment session.
10. Regarding the use of dry needling, please tick one of the following:
    - I am comfortable and give my full consent for the use of dry needling in my treatment, if necessary ☐
    - I need more information on dry needling before giving consent for the use thereof in my treatment ☐
    - I do not give consent for the use of dry needling in my treatment ☐

PASIENT OOREENKOMS:

1. Ek bevestig dat inligting op my lêer korrek is en indien enige inligting verander, ek julle binne 14 dae in kennis sal stel van die verandering.
2. Ek gee toestemming dat Marissa Fourie fisioterapie direk behandelingkodes soos gebruik tydens behandeling, van my mediese fonds mag eis. Ek neem volle verantwoordelikheid vir die rekening en om alle fooie wat nie deur my mediese fonds betaal word nie, binne 90 dae vanaf ontvangs van my rekening te vereffen.
3. Privaatrekeninge is betaalbaar direk na konsultasie. Debiet/kredietkaarte word aanvaar. Elektroniese oorbetaling kan ook gedoen word indien so gereël met die praktyk.
4. Ek aanvaar dat indien bogenoemde nie nagekom word nie, my rekening aan ‘n prokureur/invorderaar oorhandig mag word en ek aanspreeklik sal wees vir alle regskoste om gelde in te vorder, asook invorderingskommissie en opsporingskoste.
5. Ek geen toestemming vir die deel van alle relevante ICD-10 kodes met my mediese fonds/versekering (indien van toepassing) sowel as enige ander mediese rolspelers in die span wat deel mag vorm van my behandeling.
6. Ek neem kennis daarvan dat dit van my verwag kan word, om gedeeltelik te ontklee, vir die fisioterapeut om my effektief te kan evalueer en/of behandel.
7. Ek gee toestemming dat die fisioterapeut elektriese modaliteite/apparaat op my kan gebruik en dat sy my mag behandel met tegnieke, soos deur haar aanbeveel.
8. Ek neem kennis dat enige persoonlike inligting wat deur die Praktyk van myself of my kind ingewin word, hanteer sal word in ooreenstemming met riglyne van die POPIA soos uiteengesit in die Praktyk Privaatheidsbeleid, wat beskikbaar is by www.mfouriephysio.co.za. ‘n Harde kopie is ook beskikbaar op aanvraag.
9. Indien ek nie vir ‘n afspraak opdaag sonder om vooraf te kanselleer nie, sal ek vir ‘n fooi verantwoordelik gehou kan word gelykstaande in waarde aan ‘n standaard behandelingsfooi.
10. In verband met die gebruik van droë naaldterapie, merk asseblief een van die volgende:
    - Ek is gemaklik met, en gee my volle toestemming vir die gebruik van droë naaldterapie, indien nodig ☐
    - Ek benodig meer inligting oor droë naaldterapie voordat ek kan toestem tot gebruik daarvan ☐
    - Ek gee nie toestemming vir die gebruik van droë naaldterapie in my behandeling nie ☐