Claire Kourie Physiotherapists
"Physio for Life"

Fourways Life Hospital
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Fourways
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PERSOONLIKE BESONDERHEDE **PERSONAL DETAILS**		REKENAAR NOMMER: COMPUTER NUMBER	
VAN SURNAME		MNR/MEV/MEJ MR/MRS/MISS	HUWELIKSTATUS MARITAL STATUS
ID NOMMER ID NUMBER		VOORNAAM FIRST NAMES	
GEBOORTEDATUM DATE OF BIRTH	OUDERDOM AGE	HUISTAAL HOME LANGUAGE	GETAL AFHANKLIKES NO. OF DEPENDANTS
BEROEP OCCUPATION		SEL NR. CELL NO.	
TEL.		WCA CLAIM NO. (IF APPLICABLE)	
PERSOON VERANTWOORDELIK VIR REKENING **PERSON RESPONSIBLE FOR ACCOUNT**			
VOLLE NAAM FULL NAME		ID NOMMER ID NUMBER	
WOONADRES HOME ADDRESS		SEL NR. CELL NO.	
	KODE CODE	TEL (H)	
POSADRES POSTAL ADDRESS		POSKODE POSTAL CODE	
E-POSADRES E-MAIL ADDRESS			
WERKGEWER EMPLOYER		TEL (W)	
MEDIESE FONDS **MEDICAL AID**			
FONDS FUND		NO. NR.	
HOOFLID SE NAAM MEMBER'S NAME			
NAASBESTAANDE **NEXT OF KIN**			
NAAM NAME		VERWANTSKAP RELATIONSHIP	
ADRES ADDRESS		TEL.	
VERWYS DEUR **REFERRED BY**			
NAAM NAME			
ADRES ADDRESS		TEL.	

By completing the details on the file cover and accepting treatment you acknowledge and agree to the following: -

1. All consultations are to be paid in full following each session.
2. You, the patient, or the person named as being responsible for the account on the file cover, remain responsible for the full payment of your account.
3. Late payment of accounts will attract interest at the prime rate charged by Nedbank on its overdraft facilities.
4. Accounts older than 60 days will be handed over for debt collection and blacklisting with ITC, and legal fees will also be for the account of the named person.
5. All appointments not cancelled at least 4 hours prior to your consultation will be charged in full.

I acknowledge and agree to the above.

_____ _____ _____

Print Name: Signature: Date:

Terms And Conditions

The Guarantor	Means any person who signs these terms and conditions, independently from the patient(s) or guardian, and who accepts full responsibility for payment of this invoice. The Guarantor remains liable for full outstanding balance/s, unless settled in full by the patient, parent/guardian, main member, medical aid or any other party.
Signatories	Includes the patient, guarantor, parent(s) and guardian where the patient is a minor, together or separately where the person has signed in capacity
Third Parties	"Third Parties", include but are not limited to medical practitioners, doctors, radiologist, physiotherapists, dieticians, pathologist, specialists, medical aid, Specialist Integrated Management Services (PTY) Ltd and other services providers who are involved in the provision of various services to the patient.
Payment of account	I/We, the undersigned, will be responsible for and agree to make payment for all healthcare services rendered. Details of the fees and charge rates are available in writing on request. Please note that the medical practitioner may charge fees that exceed what is covered by your medical scheme and that the undersigned will remain responsible for the balance. Should accounts not be settled within 30 days from date of invoice, the medical practitioner may omit treatment and will refer the patient to another service provider.
Recovery of cost	I agree that should my account be handed over for collection, I shall be liable for all attorney and own client fees, collection charges and all disbursements. I agree that the account and payment of account is subject to the Prescribed Rate of Interest Act and that I remain liable for mora interest on accounts that have not been settled within 60 days. I agree to inspection of and negative listing of my credit information should my account remain outstanding.
Signatories personally responsible	I/we the undersigned, signatory(ies), will be personally responsible for payments of the fee, whether the invoice has been submitted to my medical scheme or any other party for payment. The person who signed these terms and conditions, as the person responsible for payment of the fee, will remain responsible for the full outstanding amount.
Invoice due and payable	The fee becomes due and payable immediately upon presentation of a final invoice. Account 30 days and older may incur interest and be subject to extra collection fees.
Consent to access credit information	I/we, the undersigned, consent to Specialist Integrated Management Services (PTY) Ltd to obtaining from any credit bureau, or any other institution with which I/we, the undersigned, may have financial dealings any information concerning my credit and payment history.
Patient consent	I acknowledge that in providing health and/or medical serviced ("Services") to me it is necessary for third parties that are involved in the provision of services, to process my personal information. " I provide my express consent to Specialist Integrated Management Services (PTY) Ltd to process my personal information as defined in legislation for purpose of providing service and to share such personal information with "third parties" in order to provide various medical and related services to me.
Consent to Magistrates Court Jurisdiction	I/we, the undersigned hereby consent and submit in terms of section 45 of the Magistrate' Courts Act to the jurisdiction of the Pretoria Magistrate Court in respect of all actions or other proceedings which might be brought against me/us by or on behalf of Specialist Integrated Management Services (PTY) Ltd arising out of /our failure to pay the fee, irrespective of the value of the claim against me/us.
Address for Notices	The addresses provided in the details section above are the chosen addresses for all purposes, including the serving of any court documents such as summonses or notices, the payments of any communication between the parties in terms of this agreement. A party may change their chosen address by the 30 days written notice to the other party.
Notice	Every notice, consent, invoice or other communication required or permitted in terms of this contract, must be in writing. Notices may be delivered: By hand to the address referred to in the details section or any other address chosen in writing: By telefax or e-mail to the addresses telefax number or e-mail address, an acknowledgement or receipt from the recipient must be given to the sender; Or prepaid registered post to the address referred to in the details section or any other address chosen in writing.
Disclosure	I/we the undersigned, authorises Specialist Integrated Management Services (PTY) Ltd, or any attending doctor, or any other attending healthcare professional to disclose the nature of the patient's diagnosis and/or any health services rendered to the patient and all and any records or copies of records in relation thereto the patient's medical aid.
Minor Patients	Where the patient is a minor, that is unmarried and below the age of 18 years both the minor's parents and/or guardians sign these terms and conditions in both their personal and representative capacities and in so doing accept responsibility for payment of the fee in full.
Accounts and Invoices	I/we the undersigned, hereby confirm that Specialist Integrated Management Services (PTY) Ltd may use the e-mail addresses as indicated in the Patient details form, for communicating purposes on the account and/or invoice. Specialist Integrated Management Services (PTY) Ltd may use my personal information for purposes of collecting and recovering any amounts owed by myself to the Medical Practitioner.
Treatment Consent	I hereby consent to receiving physiotherapy intervention relating to treatment which may include exposure of the relevant area, physical touch, dry needling and/or electrotherapy modalities. I acknowledge that any intervention has risks. If at any time I do not feel completely comfortable or unsure of any risk, I will inform my physiotherapist immediately.
Terms & conditions	I/ we the undersigned warrant that I/we, the undersigned, have read, understand and agree to these terms and conditions set out above. I/ we the undersigned, confirm that all the personal details provided on the front side of this page are accurate and correct.

Have you applied or are you currently sequestrated?	Yes	No
Have you applied for Debt Relief in the last 3 months or are you currently under a debt relief program?	Yes	No
Are you under a administration order or have you applied for an administration order?	Yes	No

Signed at: Date: YYYY / MM / DD

PLEASE write your name and sign in the appropriate space below:		
PARENT / MAIN MEMBER	Full name:	Signature:
PATIENT (18 Years +)	Full name:	Signature:
GUARDIAN(S)	Full name:	Signature:
GUARANTOR:	Full name:	Signature:

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