Anwar Louw Physiotherapy

PATIENT DETAILS	
Surname	Prof/Dr/Mr/Mrs/Ms/Miss/Mast/Other
First Names	Home Language
I.D. No.	Date of Birth
Home Address	Age
	Tel. (H)
Code:	Tel. (W)
Postal Address	Cell
	Email
Code:	Occupation
MEDICAL AID DETAILS	
Medical Scheme	Member No.
Plan	Main Member
Main Member I.D. No.	Patient Dep Code No.
PERSON RESPONSIBLE FOR ACCOUNT	
Full Name	Prof/Dr/Mr/Mrs/Ms/Miss/Mast/Other
I.D. No.	Home Language
Tel. (H)	Tel. (W)
Cell	Email
Postal Address	
NEXT OF KIN	
Full Name	Prof/Dr/Mr/Mrs/Ms/Miss/Mast/Other
Relationship	Home Language
Tel.	Cell
REFERRED BY	
GP	Tel.
Specialist	Tel.
Other	Tel.

In accordance with The Privacy Act, all information recorded in your health records will be kept confidential. Under The Privacy Act, you have the right to access and correct your personal information held by this practice. No information will be given to a third party without your consent.

Anwar Louw
Physiotherapy

Consent & Account Agreement

I, ___________________________________, confirm that the information provided above is correct to the best of my knowledge. I give my consent to the physiotherapy assessment and treatment of my problem in accordance with the guidelines of the Health Professions Council of South Africa. *(This consent may be withdrawn at any time via communication with the physiotherapist).*

I am aware that I am permitted to be accompanied by a chaperone during any consultation with the physiotherapist, should I so choose.

I understand that once an assessment is completed, the physiotherapist will provide information regarding the treatment plan and any risks associated with the treatment if indicated.

I am aware that I have the right to decline part or all of the treatment offered to me at any time.

I undertake to pay the full cost of treatment and/or any surcharges for materials via cash, Electronic Funds Transfer (EFT) or card payment upon completion of the consultation. I undertake to settle the outstanding account within 30 days of issue of the account. If the account is not settled within 30 days, no further appointments will be offered and legal action may be taken in order to recover the outstanding amount.

Cancellation Policy:
I undertake to give at least 3 hours' notice if I am unable to attend an appointment, failing which I will be liable for the full cost of the consultation.

Patient Name _____________________Signature ____________________ Date__________

Person responsible for payment (if not the patient):
Name______________________________Relationship______________________________

Signature______________________

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