BALANCE
sport & wellness

PHYSIOTHERAPY
Claudia Lepera
Melody Fitch

***Practice No**. 0474401*

PER NO.: _____ ACC NO.: _____

PATIENT DETAILS:

TITLE: _____ FIRST NAMES: _____ SURNAME: _____

I.D. NUMBER / DATE OF BIRTH: _____

HOW DID YOU HEAR ABOUT US: _____

GENERAL PRACTITIONER / SURGEON: _____

EMPLOYERS NAME: _____

EMPLOYERS ADDRESS: _____

HOME ADDRESS: _____

_____

TELEPHONE HOME: _____ WORK: _____

CELL: _____ EMAIL: _____

(If Not Patient) PERSON RESPONSIBLE FOR ACCOUNT

TITLE: _____ FIRST NAMES: _____ SURNAME: _____

ID NO.: _____

HOME ADDRESS: _____

TELEPHONE HOME: _____ WORK: _____

CELL: _____ EMAIL: _____

MAIN MEMBER & MEDICAL AID DETAILS

TITLE: _____ FIRST NAMES: _____ SURNAME: _____

ID NO.: _____ **BENEFICIARY NO of Patient.** (Eg. 00/01/02) _____

MEDICAL AID NAME: _____ MED AID NO.: _____

TELEPHONE HOME: _____ WORK: _____

CELL: _____ EMAIL: _____

PLEASE INDICATE BY TICKING BELOW, HOW YOU WILL BE PAYING FOR YOUR TREATMENTS:

MEDICAL AID ☐ CASH / CARD ☐

I, the undersigned, hereby give consent to the following:
To pay interest at the maximum monthly rate as laid down by the Limitation and Disclosure of Finances Charges Act from the first day of each month on all overdue accounts.
To pay all Attorney and Client costs, collection commission and tracing costs if my account is handed over to an Attorney to collect as a result of my default.
I also choose the address reflected above as my chosen Domicilium Citandi et Executandi.

ALTHOUGH THIS PRACTICE IS CONTRACTED INTO MEDICAL AID, THE ACCOUNT IS OF THE PATIENT'S RESPONSIBILITY IF THE MEDICAL AID DOES NOT SETTLE THE OUTSTANDING AMOUNT.
A DISCOUNT IS OFFERED IF PAID ON THE DAY OF CONSULTATION.

PLEASE NOTE: APPOINTMENTS NEED TO BE CANCELLED 24 HOURS IN ADVANCE.

SIGNED: _____ DATE: _____