Keshri Fuchs
Moonsamy
Physiotherapist

CLIENT INFORMATION

Title: _____ First Name: _____

Last Name: _____

ID Number: ☐☐☐☐☐☐ ☐☐☐☐ ☐☐ ☐

Age: ☐☐

Gender: Male ☐ Female ☐

Residential Address: _____

Postal Address: _____

Employer: _____

Contact Numbers:

Home: ☐☐☐ – ☐☐☐ ☐☐☐☐

Work: ☐☐☐ – ☐☐☐ ☐☐☐☐

Mobile: ☐☐☐ – ☐☐☐ ☐☐☐☐

Email: _____

Referred by:

☐ Medical Practitioner

☐ Friend or Word Of Mouth

☐ Internet/Google Search

☐ Advertisement

☐ Self Referred

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MEDICAL AID INFORMATION

MEDICAL AID DETAILS:

Name of Medical Aid: _____

Medical Aid Plan: _____

Medical Aid Number: _____

Name of Main Member: _____

ID Number of Main Member: ☐☐☐☐☐☐ ☐☐☐☐ ☐☐ ☐

Employer of Main Member: _____

Contact Number of Main Member: ☐☐☐ – ☐☐☐ ☐☐☐☐

Patient Dependant Number: ☐☐☐☐

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CONSENT FORM

CONSENT BY CLIENT (INTIAL IN THE BLOCK PROVIDED)

1. I CONFIRM THAT ALL MY DETAILS ARE CORRECT. ☐

2. I TAKE FULL RESPONSIBILITY FOR PAYMENT OF THE ACCOUNT SHOULD MY MEDICAL AID FAIL TO SETTLE, OR IF THERE IS A PATIENT PORTION. ☐

3. I HEREBY GIVE CONSENT TO THE PHYSIOTHERAPY TREATMENT RENDERED BY THE PHYSIOTHERAPIST AS DECIDED BY HER, FOLLOWING A DETAILED ASSESSMENT, FOR TODAY AND ANY FUTURE TREATMENTS. ☐

4. I HEREBY GIVE CONSENT TO THE USE OF NEEDLING TECHNIQUES HOWEVER THIS WILL BE DISCUSSED WITH ME, SHOULD MY TREATMENT REQUIRE SUCH A TECHNIQUE. ☐

SIGNATURE _____ DATE _____

CONFIDENTIALITY DISCLAIMER

ALL PATIENTS INFORMATION AND TREATMENT IS STRICTLY CONFIDENTIAL, AND WILL NOT BE DISCUSSED WITH OR DIVULGED TO ANYONE.