

**PATIENT DETAILS**

Surname .....	First Names .....
Date of Birth .....	ID Number .....
Occupation .....	Marital Status .....
Tel: (H) ..... <input type="checkbox"/> (W) .....	Cell ..... <input type="checkbox"/>
Medical Aid Dependant Number (eg 00;01) .....	Please tick preferred contact number

**PERSON RESPONSIBLE FOR ACCOUNT (ACCOUNT HOLDER)**

Full Names (Mr/Mrs/Miss/Dr) .....	
ID Number .....	Relationship to Patient .....
Tel.(H) ..... (W) .....	Cell .....
Home Address.....	Code.....
Postal Address .....	Code.....
e-Mail Address .....	Name of Employer .....

**MEDICAL AID DETAILS (MAIN MEMBER)**

Medical Aid Name .....	Number .....
Medical Aid Plan/Scheme .....	
Name of Main Member .....	Main Member ID .....

**NEAREST FAMILY /FRIEND**

Name .....	Relationship .....	Tel.....
<b>FAMILY GP</b> .....		Tel.....
<b>REFERRED BY</b> .....		Tel .....

**PLEASE TURN OVER**

**DECLARATION TO BE SIGNED BY PATIENT**  
**(IF OLDER THAN 18 YEARS) &/ PERSON LIABLE FOR THIS ACCOUNT**

I hereby give consent for my diagnosis code to appear on my statement.

I understand that physiotherapy treatment involves manual (hands on) techniques and that, to treat certain conditions, I might need to remove items of clothing, but the physiotherapist will ensure my privacy and comfort at all times.

I undertake to settle my account immediately. I further undertake to pay 10% interest on any outstanding balances. I undertake to pay all legal costs, including Attorney and own clients costs and collection fees should summons be issued against me for non-payment of accounts in respect of services rendered by Williams & Meyer Physiotherapy.

***I further understand that I will be liable for appointments not cancelled at least two hours in advance.***

Signature .....  
(Account Holder)

Date .....

I have read the "Dry Needling" information in reception and I hereby

- Give consent   
Do not give consent

for the performance of Dry Needling by the physiotherapist. This technique is performed within a rehabilitative framework and that I must follow instructions given by the physiotherapist. I understand that in the event of any litigation arising consequent to this therapy, it can only be done within the jurisdiction of the Magistrate's Court. The applicant will be responsible for his own and the defendant's legal costs. I hereby indemnify the therapist and the practice against any liability arising from unforeseen circumstances.

Date: ..... Time: ..... Place: .....

Patient: .....