MILLER, MEYER & ADRIAANSE PHYSIOTHERAPISTS

021 553 3049
Meyer Practice No. 0775118
cmeyer@melkbosphysiotherapy.co.za

021 553 3694
Adriaanse Practice No. 0641111
practice@melkbosphysiotherapy.co.za

Patient Particulars:

Surname	Name
Date of Birth	Dr/Mr/Mrs/Miss/Master
I.D Number	Occupation
Home Language	GP/Specialist
Referred by	
Cell	Home
Work	E-mail
Home address	Postal address

Main member of Medical aid / Person responsible for account

Name of fund	Number
Main member Name	Surname
ID Number	
Cell of main member	
E-mail address	

Do you suffer from any of the following? If so, encircle please: Diabetes, cancer, asthma, blood pressure, osteoporosis, rheumatoid arthritis or any other health condition. ____

SIGNATURE: ______________________________ **DATE:** __________________________

I hereby declare all personal and financial information as true and correct.

Medical Aid Patients: Your account will be submitted to the Medical aid electronically, but you as the patient will be liable for any outstanding amount that has not been paid in 30 days. Our contract is with **YOU** the patient **and NOT** the medical aid. ***I GIVE CONSENT THAT MY ICD10 CODES MAY BE GIVEN TO MEDICAL AID.***

Private patients: Must please settle amount after treatment, or arrangement to be made with the practice owner.

All Patients
All appointments not **cancelled 2 hours in advance**, will be charged at full price. Your treatment fee does not include consumables.

I shall be liable for overdue accounts as follows; after a period of 60 days a 2% interest (per month) will occur. If accounts are still not settled after a period of 90 days, I will be liable for all legal costs incurred by our attorney from date of services rendered until date of payment in full and all legal costs incurred in the recovery of the outstanding amount. Should I defend the matter, I will be held responsible for costs on an attorney/client scale. The National Credit Act 34 of 2005 is not applicable to this claim. Once my account has been handed over, I understand that all dealings will be done with the DEBT COLLECTING ATTORNEYS and not our office. In the event of Divorce, the parent accompanying the minor and signing the patient form is the person responsible for settlement of this account.

I hereby declare that the billing procedures of this practice have been discussed with me, and that I do understand the conditions and implications thereof.

SIGNATURE: ______________________________ **DATE**__________________________