Denisha Pather Physiotherapy
2014/254755/07
BSc Physiotherapy (WITS)
MSc Physiotherapy (Adult Neurology) (WITS)
Neurological Rehabilitation
PR No: 0250856

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PATIENT DETAILS		PERSON RESPONSIBLE FOR ACCOUNT (If different from patient)	
Surname:	Title:	Surname:	Title:
First Names:		First Names:	
ID Number:	Age:	ID Number:	Age:
Residential Address:		Residential Address:	
	Code:		Code:
Cell Number:		Cell Number:	
Tel (work):		Tel (work):	
Tel (home):		Tel (home):	
EMAIL Address:		EMAIL Address:	
Medical Aid Name:		NEXT OF KIN	
Medical Aid Number:		Name:	
Ref Doctor:		Address:	
Employer :			Code:
Occupation:			

Contract

Denisha Pather Physiotherapy is a cash practice (accepting cash, credit- or debit cards), payable after each session you attend. You can submit your invoice to your medical aid to claim the treatment fee.

Denisha Pather Physiotherapy is a private practice and fees are structured in line with National Health Reference Price List (NHRPL) rates. Although most conditions' charges are within medical aid rates, the fee may differ from the suggested medical aid tariffs.

For your convenience, a set rate is charged for your first session as well as your follow up treatment sessions.

- **I confirm that I have been informed of the purpose of physiotherapy and I confirm that the risks and complications associated with physiotherapy have been explained to me.**
- **I agree to pay the NHRPL fee and understand that I may not be fully reimbursed by my medical aid.**
- **I understand that I am personally responsible for payment of this account should my medical aid short pay/not pay the account in full, and I understand that I am responsible for claiming the refund from my medical aid.**
- **The fee is due and payable immediately on completion of service, if no medical funds are available.**
- **Upon payment a receipt will be issued in order to claim back from the medical aid.**
- **I understand that all appointments not cancelled within 24 hours will charged for my account.**
- **I hereby confirm my above address as my DOMICILUM CITANDI AT EXECUTANDI for all purposes under this agreement and I agree that any notice sent to the above address by prepaid registered post will be deemed to have been received by me on the 3rd business day after posting it.**
- **I further agree that any notice received by me by any means and at any address will be valid for all legal purposes not withstanding that it was not sent by registered post or to my DOMICILUM CITANDI AT EXECUTANDI**
- **I have read, understood and agreed to the contents herein.**
- **I have confirmed that the particulars furnished by me are in all respects true and complete.**
- **I hereby give permission for treatment to be administered to me, to my dependents and or myself.**

PLEASE NOTE: This practice is POPI compliant and will ensure compliance with the conditions for the lawful processing of personal information.

We hereby ensure that all patients' personal information will be kept confidential and that all necessary security measures are in place.

As per the POPI Act – the patient will be informed of any data breaches.

Name: (Patient/Gaurantor/Gaurdian) .....Signature.....

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

Director: D Pather