THEOPAUW Inc
PHYSIOTHERAPY
PR. NR. 0720000608335 / CO. REG. NR. 2011/006135/21
VAT NR. 4770261065

TEL:
+27 (0)44 691 1152/3
Fax:
+27 (0)44 691 1606
WEBSITE:
www.theopauw.co.za

EMAIL:
info@theopauw.co.za
ADDRESS:
14 Norman Anderson St
Da Nova, Mossel Bay

# Patient information sheet

## 1. Patient details

Title: _____Initials: _____ Surname_____

First names_____

ID No: _____Date of birth (D/M/J)_____

Occupation: _____Employer:_____

Residential address: _____

Postal address: _____Code:_____

E-mail:_____

Tel: (H) _____Tel: (W) _____

Cell No_____ **General Practitioner**: _____

## 2. Person responsible for payment of account (if different from above)

Title: _____Initials_____ Surname_____

First names: _____

ID No: _____Date of birth D/M/J_____

Occupation: _____Employer:_____

Residential address: _____

Postal address: _____

E-mail:_____

Tel: (H) _____Tel: (W) _____

Cell No_____ Fax no : _____

## 3. Medical Aid

Name of Medical Aid: _____Main member: _____

Number _____ Option/Plan_____

**Main member Dependency code**: _____ **Patient Dependency code**: _____

## 4. Member of family (not residing at the same address)

Title: _____Initials_____Surname_____

Tel:(H) Cell

THEOPAUW Inc
PHYSIOTHERAPY
PR. NR. 0720000608335 / CO. REG. NR. 2011/006135/21
VAT NR. 4770261065

TEL:
+27 (0)44 691 1152/3
Fax:
+27 (0)44 691 1606
WEBSITE:
www.theopauw.co.za

EMAIL:
info@theopauw.co.za
ADDRESS:
14 Norman Anderson St
Da Nova, Mossel Bay

## 5. Informed consent to treatment and release of information

**CONSENT TO TREATMENT**

- o During the treatment and evaluation I might need to uncover specific body parts and I understand that I may refuse to do so if and when I do feel uncomfortable in doing so.
- o The physiotherapist will need to touch me in order to provide effective treatment and that I will inform the physiotherapists if and when I feel uncomfortable in doing so.
- o It is my right to withdraw this consent at any time or for any specific procedure or modality.
- o I have been informed of all the benefits and risks of the procedures and or modalities. I have been informed of alternative procedures and modalities.
- o I understand the procedures and possible potential complications and I had the opportunity to discuss this with the physiotherapist.
- o I hereby consent to physiotherapy procedures and modalities that will be performed on me/ my dependant: subjected to the physiotherapist performing the relevant safety tests and evaluation, and taking relevant precautions.
- o I give this consent freely and declare that it was not made under duress.

**CONSENT TO THE RELEASE OF INFORMATION**

Consent is hereby given to Theo Pauw Inc to disclose information regarding my diagnosis (ICD 10 Coding), medical condition, prognosis, treatment compliance and treatment program for account rendering purposes and appropriate on-referral. Any other information release will be discussed with the signatory accordance with the POPI Act (Act no 4 of 2013)
I fully understand that this is a legal requirement and that I have a choice not to consent to such information being disclosed to any party. I confirm that I have exercised my choice voluntarily and that this declaration and exercise of my choices was not made under duress.
I indemnify Theo Pauw Inc from any liability, damages or whatsoever that I may suffer as a result of this disclosure and that I will hold Theo Pauw Inc harmless of any further disclosures and prejudice I may suffer as a result of such disclosures.

## 6. Agreement of payment

Please note that you are personally responsible for the payment of your account. Accounts are sent electronically to most medical aids. If your medical aid does not pay, you remain responsible for payment. This practice charges NRHPL / Discovery rates through a switching company. Payments may be made electronically, by cheque or cash. We do have card facilities as well.
I hereby accept full financial responsibility for this account until it is settled. I understand that I will be responsible for all legal fees involved, if legal action is needed to collect any outstanding fees. I hereby declare all personal and financial information as true and correct. 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. I declare that this consent was not made under duress.

**Signed (person accountable for payment):**_____**Date:** _____

## 7. Signatures

SIGNED AND DATED at _____on this _____day of_____ 20_____

Physiotherapist (name)) _____ Signature _____

Witness (name) _____ Signature _____

**Patient (name)** **Signature**

**Witness (name)** Signature

_____ _____