Juan Carstens Physiotherapy & Prehab

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1. PATIENT INFORMATION

Title: _____ Surname: _____ Initials: _____

Full Names: _____ Gender: Male / Female

ID/Passport number: _____ Date Of Birth: _____

Physical Address:

_____

_____

_____

_____

Postal Code: _____

Contact Information:

Cell: _____

Home: _____

Work: _____

Email: _____

Next Of Kin: _____

Contact Number: _____

2. MEDICAL AID DETAILS

Name Of Medical Aid: _____

Name Of Main Member: _____ Medical Aid Plan: _____

Medical Aid Number: _____

3. HOW DID YOU HEAR OF THE PRACTICE?

Word of mouth Internet Dr Referral Advertising Social Media

Other Please Specify: _____

4. ANY UNDERLYING MEDICAL CONDITIONS:

Pregnancy Osteoporosis Arthritis Cancer Metal Implants

TB Pacemaker Cardiovascular Disease Hypertension

Diabetes Allergies Other Please Specify: _____

5. Important Information:

- Juan Carstens Physiotherapy & Prehab is a private practice and is not contracted into medical aid. An invoice will be issued with ICD 10 codes that will be sent to the patient for submission to the medical aid. Please note that the full amount may not be reimbursed from the medical aid since we charge private practice rates.
- Please be advised that you are responsible to settle your account immediately after each session. The practice accepts cash, cards and electronic payments.
- Unkept appointments will be charged for the full amount unless cancelled 24 hours beforehand
- Juan Carstens Physiotherapy & Prehab shall not be held accountable for any injuries obtained on the premises.

6. Consent:

- I give consent to be treated by the physiotherapist Juan Carstens. I acknowledge that I am aware of the covid-19 pandemic and by attending this session I understand that I expose myself to a slightly increased risk of a viral infection.
- I give consent to the removal of certain clothes necessary for effective treatment. If you feel uncomfortable at any stage during the session, please do not hesitate to inform the physiotherapist.
- I give consent to take part in therapeutic physical activity. I understand it is my responsibility to inform the physiotherapist of any underlying medical conditions and any difficulties experienced during exercise or treatment.
- I give consent that personal, medical and account details may be shared with other medical professionals.

Name: _____ Signed: _____

Date: _____