

PATIENT INFORMATION

Please fill in all of the following information.

Should you have any difficulty filling in any of the information, we will be glad to assist you.

PERSONAL DETAILS

Patient's Name			
Date of Birth			
Referring Doctor			
Postal:		Home:	
Tel: Work		Tel: Home	
Cell:		ID No:	
Name of Employer		Email:	

MEDICAL AID DETAILS

Name of Principal Member			
Name of Medical Aid			
Medical Aid Number			
Identity No. of Principal Member			

WORKERS COMPENSATION PATIENTS ONLY

Name and Address of Employer		Contact Person at Employer
Tel. Number of Contact Person		
WCA Claim Number		
Date of Injury		

EMERGENCY DETAILS

Nearest Family or friend			
Tel No. of Emergency Contact			
General Practitioner		GP Tel.	

Please Note:

All Accounts **MUST** be settled after each therapy visit.

This practice is contracted out of all Medical Aid Schemes.

The rate charged may be different from the amount you may be reimbursed by your medical aid.

You will be given a receipt which you may submit to your Medical Aid for reimbursement.

You may pay with cash or credit card (visa or mastercard only)

I agree that I am responsible for complete payment of my account. I authorise this practice to debit my credit card should I select this method of payment.

All appointments not cancelled 24 hours in advance will be charged at the full rate.

All reports, forms to be filled in and letters of motivation requested by/for a patient are charged at R250.00

I agree that I will pay all collection fees, expenses, commission, tracing charges and interest should debt collection or attorneys be required for the settlement of this account. I further consent to your being entitled to obtain credit information concerning myself /person responsible for the account at any time and lodge, exchange and disclose such information with any credit bureau without any further notice to me.

Signature: _____ **Date:** _____

Name (printed) of Signatory: _____

POPIA Consent Statement

I (Patient/ guardian), _____, the undersigned acknowledge that Jennifer Blenkinsop Occupational Therapy is committed to conducting the practice in accordance with the law in order to ensure that the confidentiality of your personal information is protected and maintained.

I confirm that I have been informed of the practice's Privacy Statement, which is available from the practice on request or on the practice website www.jenniferblenkinsop.co.za .I confirm that I have been offered adequate opportunity to read this Statement and that I fully understand my rights in respect of my information held by the practice and how the practice will process my personal information and with whom it will be shared. I confirm that I have had any questions satisfactorily answered.

I confirm that I provide consent of my own free will without any undue influence from any person whatsoever. I have received all the information required to provide consent.

I consent to the following specific processing activities of my personal information by the practice:

- a. the submission of my accounts to my medical scheme / other funder
- b. the submission of information relevant to my diagnosis and treatment to my medical scheme / other funder, if required
- c. the inclusion of relevant health information in referral letters and when providing reports about my treatment to referring practitioners
- d. to sharing of relevant information with bodies performing peer review of practitioners or clinica practice audits, subject to confidentiality undertakings

Name (printed): _____

Signature: _____ Date: _____