

CONFIDENTIAL

**Nel and Andrea Physiotherapists**

Practice Number 0453315

Account
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**1. Patient Details/ PasiëntBesonderhede**

Surname Van		First Name Voornaam	Title Titel
Date of Birth Geboortedatum		I.D. Number I.D. Nommer	
Occupation Beroep		Home Language Huistaal	Marital Status Huwelikstatus
Tel (H)	Tel (W)	Tel(C)	
E-mail E-pos			
Alternative Contact Person AlternatieweKontakpersoon		Tel (C) Tel (H)	Relationship Verwantskap

**2. Person Responsible for Account/ Persoonverantwoordelikvirrekening**

Full Name VolleNaam		Title Titel	
I.D. Number I.D. Nommer			
Home Address Woonadres		Code Kode	
Postal Address Posadres		Code Kode	
Employer Werkgewer			
Work Address Werkadres		Code Kode	
Tel(C)	Tel (H)	Tel (W)	Fax
E-mail E-pos			

**3. Medical Aid/MedieseFonds**

Medical Aid MedieseFonds	Dependant Code	Plan
Member Name HooflidNaam		Number Nommer

**4. Injury on Duty/BeseringaanDiens(For Office use)**

Date of injury Datum van Besering		WCA	Number of Cases AantalGevalle
OT	Y	N	Date of OT Appointment Datum van OT Afspraak
		Exercise Class OefenKlas	Date Datum
Area of Injury Aard van besering		Date Discharged Datum van Ontslag	

**5. Referred by/Verwysdeur(For Office use)**

Name Naam	Date of Referral Datum van Verwysing	Follow Up Date Opvolg Datum
Progress Report Vorderingsverslag		

This account remains your responsibility until fully paid. Regular follow ups by the member with the medical aid may be required to ensure prompt payment. In the case of your medical aid not paying the full account you will be liable for the balance.

Die rekeningbly u verantwoordelikheidtotdatdit ten vollevereffen is. U is dus self daarvoorverantwoordelik om die rekening by u medieseFonds op tevolg op n gereelde basis. Indien u medieseFondsnie die vollebedragvereffennie, sal u aanspreeklikwees vir die balans.

I understand and accept the terms above.

Ekverstaanenaanvaar die termehierbo.

Signed..... Date.....

Geteken..... Datum.....