Vicki Hofmann
WENDY YOUNG OCCUPATIONAL THERAPY INC.

Suite 16A,
Gate 2
Medigate Centre
Umhlanga

Practice No. 0760013
VAT: 4250280551

Tel: 031 566 4239
Fax: 031 566 4239
Cell: 082 465 3251
admin@vickihofmannot.co.za

83 Cleland Road
Hayfields
Pietermaritzburg
3201

PERSONAL INFORMATION SHEET

I, the undersigned understand that, in my personal capacity, I stay responsible for the settlement of any costs for the services that I or my dependant will receive, whether I make provision towards paying my account in any of the following matters: cash, debit or credit card, EFT

INFORMATION: PATIENT

Surname	First: First Name	Middle: Initial	Choose an Item			
			Mr.	Mrs.	Miss	Ms

Relationship to Main Member	Dependent Code	Birth date	Age	Sex	
		D D M M Y Y		M	F

Identity No													Email	

INFORMATION: PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

Surname	First: First Name	Middle: Initial	Choose an Item			
			Mr.	Mrs.	Miss	Ms

Marital status:					Birth date	Age	Sex	
Single	Married	Divorced	Separated	Widowed	D D M M Y Y		M	F

Identity No													Preferred Language for Statement	

Physical Address		Postal Code	
		Cell No	
Postal Address		Postal Code	
		Home Tel No	
Occupation		Employer		Work Tel No	

Are you under debt review and/or under an existing Administration Order issued by a competent Court for the management of your debts?	YES	NO

MEDICAL SCHEME INFORMATION (PLEASE GIVE YOUR MEDICAL SCHEME CARD TO THE RECEPTIONIST)

Main Member						
Surname	First: First Name	Middle: Initial	Choose an Item			
			Mr.	Mrs.	Miss	Ms

Medical Scheme Aid Name	Benefit Plan Option	Medical Scheme Aid Number

TERMS & CONDITIONS

1. The above information is true to the best of my knowledge.
2. I have acquainted myself with all the terms and tariffs applicable and have noted that:
   a. The terms and a copy of the tariffs applicable to private patients are available from reception;
   b. The terms and tariffs for patients covered by medical aid schemes vary. I understand that I must communicate directly with my medical aid scheme for the applicable tariffs and reimbursement. This practice does not charge medical scheme tariffs.
3. I hereby warrant that (if applicable):
   a. The patient is a bona fide member of the medical aid scheme mentioned herein and his / her membership is valid as at the date of the signature of this agreement; or
   b. I am a bona fide member of the medical aid scheme mentioned herein and my membership is valid as at the date of the signature of this agreement, and the patient is a bona fide dependent in terms of such membership; and
   c. I have not been sequestrated and do not suffer from any legal or contractual disability.
4. I choose as domicilium citandi et executandi the address detailed on the front page of this application form.
5. I confirm that:
   a. I affixed my signature hereto willingly and without any duress;
   b. I agree to these and the payment policy terms and conditions; and
   c. No misrepresentation with regards to the content hereof has been made.
6. I acknowledge receipt of the following policies:
   - ☐ Practice Payment Policy
   - ☐ POPI Section 18 Practice Privacy Notification is available on request. I have the right to review the Privacy Notification prior to signing this consent.
   - ☐ Authorisation for Release of Personal Information (Third Parties)
   - ☐ Patient Consent for the use of electronic Communications
7. I understand that by signing this information sheet form I give consent for:
   - ☐ Medical treatment (patient)
   - ☐ Processing of my personal information
   - ☐ Taking responsibility for the payment of the account as set out in the Practice Payment Policy.

Patient/Guardian signature _____ Date _____

Responsible Person / Main Member signature _____ Date _____