FRANCOIS PRETORIUS PHYSIOTHERAPY
BSc Physiotherapy (Hons) UFS, MBA US | HPCSA PT0057207 | Practice 7239327
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NEW PATIENT INTAKE

Please complete both pages. Treatment consent will be discussed and recorded during your assessment.

1 PATIENT AND CONTACT DETAILS

Full names and surname	**Preferred name**
Date of birth ____ / ____ / _____	**ID / passport (medical scheme or claim)**
Cell / telephone	**Email (used for billing and documents)**
Residential address	

Patient is a minor: ☐ No ☐ Yes

If a parent, guardian or authorised representative is completing this form:

Representative name	Relationship / authority
Cell	ID / proof of authority (where needed)

2 FUNDING, ACCOUNT AND REFERRAL

☐ Private / self-pay	☐ Medical scheme
☐ COIDA / injury on duty	☐ RAF / insurer
Medical scheme / funder	Member / claim number
Main member / claimant	Dependent code
Person responsible for account (if different)	Cell / email
Referring practitioner / facility	Practice number / contact (if known)

Emergency contact: Name _____ Relationship _____ Cell _____

3 ACCOUNT, CLAIMS, COLLECTIONS AND PRIVACY

☐ ACCOUNT: Private/self-pay fees are due immediately after each consultation. If a medical scheme, COIDA, RAF, insurer or other funder rejects, short-pays or does not settle a claim, the patient or person responsible for the account must pay the outstanding balance within 7 calendar days after the statement is sent by email.

☐ CLAIMS: Where funding is indicated above, I authorise the practice to submit the minimum information reasonably required for payment, including relevant service and ICD-10 information, to the funder, its administrator and the person responsible for the account.

☐ COLLECTIONS: The practice may send statements and reminders by email and follow up by telephone or WhatsApp. An overdue account may be subject to a written demand and may be handed over or ceded to a registered debt collector or attorney. For recovery, the practice may disclose the minimum identity, contact, account and supporting billing information reasonably necessary to establish and collect the debt. Clinical notes are not routinely disclosed.

☐ RECOVERY CHARGES AND CREDIT REPORTING: The practice does not charge its own interest. After handover, statutory collection fees, necessary expenses, legal costs and interest may be added only where lawfully recoverable by the registered debt collector, attorney or court. If all legal requirements and required prior notice have been met, adverse payment information may be reported to a registered credit bureau. Reporting is not automatic.

PRIVACY: The practice uses information for care, clinical records, appointments, billing, claims, collections and legal/professional duties. The minimum necessary information may be shared with authorised practitioners, funders, service providers, debt collectors, attorneys and credit bureaux where lawful. The full POPIA Privacy Notice is available at reception and at francois-pretorius-physiotherapy.physiofp.chatgpt.site/privacy.

I confirm that the information supplied is accurate. If I am the patient or person responsible for the account, I accept the account, claim and collection terms above. I acknowledge that the Privacy Notice is available. Treatment consent is discussed during the assessment; this signature is not blanket consent to treatment.

Patient / responsible person / representative	**Capacity**
Signature	**Date** ____ / ____ / _____

Patient name _____ **Date of birth** ____ / ____ / _____

Please answer each question. A 'Yes' answer requires clinical follow-up before or during the assessment; it does not by itself establish a diagnosis.

4 BRIEF RED-FLAG SCREEN

QUESTION	RESPONSE
Recent significant fall/accident, severe trauma, or new inability to bear weight or use the affected limb?	☐ No ☐ Yes
New loss of bladder or bowel control, difficulty passing urine, or numbness around the groin/saddle area?	☐ No ☐ Yes
New or rapidly worsening weakness, loss of coordination/balance, or difficulty walking?	☐ No ☐ Yes
Chest pain, unexplained shortness of breath, coughing blood, fainting, or a hot/swollen/painful calf or limb?	☐ No ☐ Yes
Fever or feeling acutely unwell together with severe or rapidly worsening pain?	☐ No ☐ Yes
Unexplained weight loss or night sweats, previous cancer, or constant pain that is not eased by rest?	☐ No ☐ Yes
A sudden severe headache or neck pain with double vision, trouble speaking/swallowing, facial numbness or limb weakness?	☐ No ☐ Yes
Known porphyria or close family history, or a current unexplained episode of severe abdominal pain with dark/reddish urine, marked weakness or confusion?	☐ No ☐ Yes

If you answered Yes, briefly explain: _____

_____

Patient / representative initials _____ Date ____ / ____ / _____

PRACTITIONER REVIEW

☐ Form reviewed ☐ Positive answers followed up ☐ Action/referral recorded ☐ Capacity/authority confirmed where applicable

Practitioner name _____ Signature _____ Date/time _____