Dr.
VICKI FERREIRA
CHIROPRACTOR

Dr Vicki Ferreira Chiropractor **Practice Number: 0680303**
M.Tech (UJ) **AHP CSA: A11834**

PATIENT INFORMATION (BABY INFORMATION)	
ID NUMBER	DATE OF BIRTH
SURNAME	FULL NAME(S)
RESIDENTIAL ADDRESS	
EMAIL	CELLPHONE
CLOSEST FRIEND OR RELATIVE	
SURNAME	FULL NAME(S)
CELLPHONE NUMBER	RELATIONSHIP

PRIVATE PATIENTS

- Payments are made immediately after a treatment session. Cash/debit/credit card facilities are available. Accounts outstanding for longer than three months will be handed over to debt-collectors, unless a prior payment arrangement has been made. Admin fees and interest will be added.

MEDICAL AID PATIENTS

Ensure the receptionist has made a copy of your medical aid card if you prefer this method of payment

MEDICAL AID SCHEME	MAIN MEMBER NAME
PLAN/OPTION	MAIN MEMBER ID NUMBER
MEMBERSHIP NUMBER	PATIENT DEPENDANT NUMBER

- The treatment costs are in accordance to the National Referencing Price List (NRPL), i.e. these are medical aid rates; no co-payment is required. In the case where a medical aid does not pay out, the person responsible for the account must then settle the outstanding amount within 30 days of treatment date. An admin fee of 10% will be added to my account for every month that my account is outstanding.

CONSENT

- I understand that the practice is entitled to charge me if an appointment is not kept or not cancelled 12 hours in advance. I consent that my medical records may be disclosed or made available to other medical professionals. I undertake to inform the practice of any change in address, medical aid details or personal information. I acknowledge that any administration, legal or debt collecting fees will be charged to me. If I fail to meet my obligations, the practice may report non-performance with the appropriate financial bureaus. I understand that chiropractic treatments may involve the exposure of relevant areas, physical touch (including adjustments to the spine, pelvis and

extremities), dry needling, etc. I am aware that although extremely rare, some physical treatments may have risks, such as a fracture, muscle soreness, stiffness, a stroke, etc. I will inform my chiropractor immediately if I am uncomfortable, concerned or uncertain about the treatment procedures.

- In the case of a minor receiving treatment, the legal guardian will sign for consent of treatment.

I, (full name and surname)_____ confirm that I have read the above information and give my informed consent to begin treatment. I have also supplied the practice with the correct information.

SIGNATURE	DATE	ID NUMBER

NAME OF CHILD	**AGE**	**NAME OF PARENT (S)**
SISTER	**PAEDIATRICIAN**	**GYNAECOLOGIST**

Pregnancy History:

Duration of pregnancy:	Method of Delivery:
Any complications for mom and/or baby:	
APGAR:	Current weight:
Birth Length:	Current length:
Birth Weight:	How many nappies per day:
Head circumference:	
Breast or formula:	If formula, please specify:
Probiotic:	