**MALCOLM FREEDMAN – ORTHOTIST AND PROSTHETIST**
**PRACTICE NO. 0870000122580 HPCSA REGISTRATION – OS 5711**

| **DETAILS OF PATIENT** | | | | | | | |
|---|---|---|---|---|---|---|---|
| TITLE | | INITIALS | | SURNAME | | | |
| FULL NAME | | | | | | DATE OF BIRTH | |
| I.D. NO. | | | | CELL NO. | | | |
| TEL. HOME | | | | TEL. WORK | | | |
| EMAIL ADDRESS: | | | | | | | |
| POSTAL ADDRESS | | | | RESIDENTIAL ADDRESS | | | |
| | | | | | | | |
| | | | | | | | |
| | POSTAL CODE | | | | POSTAL CODE | | |

| **DETAILS OF PERSON RESPONSIBLE FOR ACCOUNT** | | | | | | | |
|---|---|---|---|---|---|---|---|
| TITLE | | INITIALS | | SURNAME | | | |
| I.D. NO. | | | | RELATIONSHIP TO PATIENT | | | |
| POSTAL ADDRESS | | | | RESIDENTIAL ADDRESS | | | |
| | | | | | | | |
| | | | | | | | |
| | POSTAL CODE | | | | POSTAL CODE | | |
| TEL. HOME | | | | TEL. WORK | | | |
| CELL NO. | | | | EMAIL ADDRESS | | | |

| **MEDICAL AID DETAILS** | | | |
|---|---|---|---|
| MEDICAL AID NAME | | PLAN TYPE | |
| MEDICAL AID NO. | | MAIN MEMBER | |
| DEPENDANT NAME | | | |
| REFERRING DOCTOR | | | |

| **EMPLOYER DETAILS** | |
|---|---|
| EMPLOYER | |
| EMPLOYER ADDRESS | |
| EMPLOYER PHONE | |

| **NEXT OF KIN** | | | |
|---|---|---|---|
| NAME | | RELATIONSHIP | |
| TEL. HOME | | TEL. WORK | |
| CELL NO. | | | |

**Please note that there is a <u>10% handling fee</u> which will be charged on any items being returned. *NO RETURNS AFTER 7 DAYS***
**I understand and agree that I am ultimately responsible for the entire account and that the cost of my Medical Care may well exceed the amount(s) reimbursed by my Medical Aid or Insurance Scheme. I agree to pay any and all costs necessary for debt collection including attorney's fee, should this become necessary. All accounts NOT settled by your medical aid 30 days after submission will become payable by the member immediately.**

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**Print name Signature Date**