



G. LUKONGA PHYSIOTHERAPY

— Move Better. *Live Better.* —

PR. 0815306

MEDICAL AID INFORMATION

1. PATIENT INFORMATION

Full Name: _____

ID / Passport Number: _____

Date of Birth (DD/MM/YYYY): _____

Contact Number: _____

Email (optional): _____

Physical Address: _____

Postal Address (if different): _____

City / Suburb: _____ Postal Code: _____

Occupation: _____

2. MEDICAL AID DETAILS

Medical Aid Name: _____

Main Member Name: _____

Main Member ID Number: _____

Relationship to Main Member: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Medical Aid Plan / Option: _____

Plan Type: ☐ Medical Savings Account (MSA) ☐ Traditional ☐ Restricted

Main Member Contact Number: _____

Main Member Email (if available): _____

3. AUTHORISATION & FINANCIAL RESPONSIBILITY

- I understand that it is my responsibility to ensure that sufficient benefits are available for treatment.
- I understand that any shortfall, co-payments, deductibles, or non-covered services will be my responsibility.
- I authorise G Lukonga Physiotherapy to submit medical aid claims on my behalf and to release any information required for this purpose.
- I understand that payment for services is due if my medical aid does not cover the full amount.

Authorisation Signature: _____

Date (DD/MM/YYYY): _____

4. DECLARATION

I declare that the above information is true and correct. I will inform the practice of any changes to my medical aid details.

Patient / Main Member Signature: _____ Date (DD/MM/YYYY): _____



+27 11 845 7027



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admin@lukongatherapy.co.za



121 Wooton Avenue cm Harrison street, Benoni

Life Dalview Hospital

11 Hendrik Potgieter Road (Ref. House 2 Dr. Malanda)

Dalview 1541, Brakpan



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