



G. LUKONGA PHYSIOTHERAPY

— Move Better. Live Better. —

PATIENT CONSENT FORM

1. PATIENT INFORMATION

Full Names and Surname: _____

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

ID / Passport Number: _____

Contact Number: _____

Email (optional): _____

Address: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

2. NATURE OF TREATMENT

I hereby consent to undergo physiotherapy assessment, treatment and related services provided by G Lukonga Physiotherapy.

I understand that the purpose of treatment is to improve my physical function, reduce pain, and promote rehabilitation.

The nature of the treatment, as well as its benefits and possible side effects, has been explained to me in a language that I understand.

3. CLIENT CONSENT & DECLARATION

I, hereby consent to all my and my dependants' personal information being recorded and/or used and/or shared, as may be necessary, to provide the best professional service to the patient. Patient will be held liable for a portion or the full consultation fee

(in the sole discretion of this Practice), should the appointment made not be honoured or cancelled at least 24 (twenty-four) hours prior to the scheduled appointment.

I undertake to promptly pay all accounts received from this Practice. I accept that I am fully responsible for the payment in respect of professional services rendered, and should I not settle the accounts timeously, I understand that I will be held liable for debt recovery costs on an attorney and own client scale. Should any of my or my dependants' personal information change or I no longer wish to honour these terms and conditions, I shall immediately notify this Practice.

I understand and accept the aforementioned terms and conditions.

4. CONSENT

Patient / Parent / Guardian Name: _____

Signature: _____

Date: (DD/MM/YYYY) _____

(If the patient is a minor, consent must be provided by a parent or legal guardian.)



+27 11 845 7027



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admin@lukongatherapy.co.za



121 Wooton Avenue crn Harrison street, Benoni

Life Dalview Hospital

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

Dalview 1541, Brakpan



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