INNATE BALANCE

INNATE BALANCE COMMUNITY HEALTH

APPLICATION FOR HEALTH CARE

DATE: _____ CONTACT NO. _____

ALTERNATIVE CONTACT NAME: _____

ALTERNATIVE CONTACT NUMBER: _____

NAME AND SURNAME: _____

DATE OF BIRTH: _____

WHERE DID YOU HEAR ABOUT US? _____

WHAT DO YOU NEED HELP WITH? _____

_____

_____

_____

PLEASE MOTIVATE YOUR NEED FOR SUBSIDISED HEALTH CARE: _____

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Terms and Conditions

- An application fee of R50 is required on submission of your application before an appointment can be made.
- Please email your application and proof of payment to docandy@innatebalance.co.za to secure an appointment.

- Payment for your application can be made to:
  Innate Balance
  Nedbank Current Account
  Account Number: 118 307 1515
  Reference: Your Name and Surname
- In the event of an appointment being missed or cancelled with less than 12hrs notice, a new application form will need to be submitted with the required R50 application fee to secure a new appointment.
- Appointments and treatment duration are at the discretion of each practitioner individually. If you are dissatisfied with the treatment you receive you may send in a new application and include your reason for requesting a different practitioner.
- Please note that the information on this form will be distributed within the organisation (Innate Balance Community Health). All members of the organisation are under legal obligation to keep your personal information confidential within the confines of the organisation and its members. If you agree to the aforementioned please tick the box ☐
- After submitting your application, if you have not been contacted within 7 days for an appointment, please notify us by email.

I, the undersigned, understand all of the information contained within this application form and agree to the terms and conditions herein. I also confirm that all information provided by me is true and correct.

FULL NAME OF APPLICANT: _____

DATE: _____ SIGNATURE OF APPLICANT: _____