PARTICULARS OF APPLICANT

Surname: _____

Christian Names: _____

Call name/Nickname: _____

Date of Birth: _____ I.D.: _____

Country: _____ City: _____

Age: _____ Gender: _____

Referred by: _____

Substances Abused: _____

How often? _____

Drug of introduction: _____ Age started using: _____

Current prescribed medication: _____

Allergies / medical conditions: _____

When last did the applicant use substance/s: _____

Do you require a medical aid invoice? (Please note the cost of administering medical aid reimbursements is R500.00 should this require additional administration besides the usual medical aid invoices):

_____

Date of arrival: _____

Previous rehabilitation centres attended:	Duration of stay (& year attended):
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Particulars of Parents/Sponsor/Guardian

Names and Surnames: _____

Home and/or Postal Address: _____

Tel (H) _____ (W) _____ (C) _____

E-mail address: _____

Next of Kin of Applicant: _____ Relationship: _____

Tel (H) _____ (W) _____ (C) _____

E-mail address: _____

Disclaimer:
By signing this document, I hereby confirm that all information disclosed and signed for on this document is (to my knowledge) 100% correct and accurate and that I have not failed to disclose or include any information which may prove vital.

Applicant Name: _____

ACCOUNT INFORMATION:

Name and Surname: of Financial Sponsor:_____

Contact Number: (h)_____ (w)_____ (c)_____

Email address:_____

Fax number:_____

Billing information:

Invoices to be made out to:_____

VAT number (if applicable):_____

Postal/Residential Address:_____

Medical Aid Invoice required? (yes/no): _____

Medical Aid Scheme:_____

Membership number:_____

Dependant code:_____

Main members name:_____

Main Members ID number:_____

PREAUTHORISATION NUMBER FROM MEDICAL AID:_____

- Healing Wings does NOT claim directly from Medical Aid. Invoices are payable to Healing Wings and we will submit a Medical Aid invoice to you, for you to apply for reimbursement, provided all information is correct and has been provided to us. Healing Wings is not responsible for the follow-up of reimbursement payments to the member. PLEASE NOTE THAT THE PATIENT NEEDS TO REQUEST A PREAUTHORISATION NUMBER FROM MEDICAL AID PRIOR TO ADMISSION TO HEALING WINGS IN ORDER TO AVOID REIMBURSEMENT PENALTIES BEING ISSUED BY THE MEDICAL AID. Please note that a new authorization number needs to be issued EACH year, and the medical aid needs to be notified again on 01 January if applicable.

NB!!! ON APPLICATION:

- A BRIEF BACKGROUND HISTORY OF THE APPLICANT *MUST* BE E-MAILED TO HEALING WINGS SOUTH AFRICA
- THE RESIDENT *MUST* BRING A THOROUGH MEDICAL REPORT (PAGE 15)
- ALL PRESCRIPTIONS AND MEDICAL DOCUMENTATION, AS WELL AS 2 - 3 WEEK'S SUPPLY OF ALL PRESCRIPTION MEDICATION MUST ACCOMPANY THE RESIDENT ON ARRIVAL
- PLEASE ENSURE THAT DENTAL TREATMENT IS COMPLETE AS FAR AS POSSIBLE BEFORE ARRIVAL
- PLEASE ENSURE THAT SIGNED FORMS ARE RETURNED VIA EMAIL BEFORE ARRIVAL
- 2 x ID PHOTOS MUST ACCOMPANY THE RESIDENT – this is a legal requirement!
- ALL RESIDENTS ARE TO BE INTERVIEWED PRIOR TO ACCEPTANCE
- PLEASE CONFIRM TRAVEL DETAILS WITH THE OFFICE PRIOR TO BOOKING, TO ENSURE COLLECTION ON TRIP DAYS
- PLEASE KINDLY SUPPLY US WITH ANY PREVIOUS PROFESSIONAL REPORTS FROM PSYCHIATRISTS OR OTHER INSTITUTIONS TO ASSIST US IN PROVIDING THE BEST POSSIBLE TREATMEN

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Applicant Name: _____

LETTER OF INDEMNITY (PARENT, SPONSOR OR GUARDIAN)

To be read and signed by legal guardians and sponsors.

On behalf of myself, my executors, administrators, heirs and successors, I undertake not to claim from, nor institute legal action against Healing Wings South Africa, its owners, members, employers, agents or helpers. I hereby indemnify and absolve them from any liability or claims of any nature whatsoever arising from damage, loss or death, to my property or person, or any minor person for whom I am responsible, whether arising from accident, negligence or any cause whatsoever. I understand that Healing Wings will not be held liable for the direct or indirect effects or consequences of any pre-existing medical conditions. I also undertake to pay all costs which may be incurred for medical or other treatment by any person or organization who gives services in the event of an emergency and requires payment for them as well as any transportation or evacuation costs which may be necessary whether by vehicle or aircraft or any other means whether these be for me or any person for whom I am responsible.

----------(Parent/Sponsor/Legal Guardian)

----------Day of----------201------

LETTER OF INDEMNITY (APPLICANT)

To be read and signed:

On behalf of myself, my executors, administrators, heirs and successors, I undertake not to claim from, nor institute legal action against Healing Wings South Africa, its owners, members, employers, agents or helpers. I hereby indemnify and absolve them from any liability or claims of any nature whatsoever arising from damage, loss or death, to my property or person, or any minor person for whom I am responsible whether arising from accident, negligence or any cause whatsoever. I understand that Healing Wings will not be held liable for the direct or indirect effects or consequences of any pre-existing medical conditions. I also undertake to pay all costs which may be incurred for medical or other treatment by any person or organization who gives services in the event of an emergency and requires payment for them as well as any transportation or evacuation costs which may be necessary whether by vehicle or aircraft or any other means whether these be for me or any person for whom I am responsible.

----------(Name of Applicant)

Have read, understood and agree to the contents of the above and hereby on the:

----------Day of----------201------

Sign in the acknowledgement thereof:

Applicant ----------

Disclaimer:
By signing this document, I hereby confirm that all information disclosed and signed for on this document is (to my knowledge) 100% correct and accurate and that I have not failed to disclose or include any information which may prove vital.

Applicant Name: _____