Patricia de Caires
PHYSIOTHRAPY

Practice nr. 110 9057

Patient details		Mr	Ms	Mrs	Miss	Dr	Prof
Surname:		Occupation:					
First names:		Physical Address:					
ID Number:							
Date of birth:	Age:						
Contact number:		Email Address:					

Person responsible for the account	*(Please complete If person responsible is <u>not</u> the patient)*
Surname:	Relationship to patient:
First names:	Physical Address:
ID Number:	
Contact number:	
Alternative contact number:	Email Address:

Medical aid details	Membership number:		
Medical Scheme:	Medical plan:		
Name of main member:	Main member ID number:		
Dependant Code:	Submit to medical aid:	YES	NO

Next of kin	Name & Surname:
Contact number:	Relationship to patient:
Referring / Treating Doctor	Doctor's Name:
Contact number:	Practice no:

I hereby acknowledge that the above information is true and correct. Medical Schemes will reject accounts with incomplete patient and Doctor details.

CONSENT FORM

Thank you for choosing Patricia de Caires physiotherapy. I look forward to assisting you in finding solutions and a way forward with your treatment journey. Please would you take the time to read through the terms and conditions listed below before consenting to your treatment.

- I understand that this is a **cash practice**, and the account will be sent directly to me, unless there is a PMB approval by my medical aid and an agreement has been made between myself and the practice owner whereby claims may be sent directly to the medical aid.
    - I understand that should my claim be sent to my medical scheme; it may not pay for the treatment rendered. If this is the case, then I understand that I am liable for any outstanding fees.
    - I understand that it is my responsibility to liaise and confirm with my medical aid regarding benefits and funds available for the use of physiotherapy management.
- I understand that I am personally responsible for payment of the account. The fee is due and payable immediately on completion of the service. A statement will be emailed to me to claim back from the medical aid.
- The account is rendered directly to you as required by the medical schemes act No: 131 of 1998 and I agree to pay the physiotherapist fee.
- I understand that I have a separate agreement with my medical scheme which may not fully reimburse me.
- I agree to inform the physiotherapy at least 4 hours before my appointment should I wish to cancel unless an emergency occurs.
- **A missed appointment will be charged at R400 per missed session.**
- I hereby declare that the billing procedures of this practice have been discussed with me and that I understand the conditions and implications thereof.
- I understand that I will be responsible for all legal fees involved, if legal action is needed to collect any outstanding fees.
- I understand that I will be responsible for all costs and interest incurred over unpaid accounts.
- I declare that this consent was not made under duress.
- I have read understood and agree to the contents herein.
- I confirm that the particulars furnished by me are in all respects true and complete.

PATIENT INFORMATION AND CONSENT TO TREATMENT

Please note that all treatments that are carried out through Patricia de Caires Physiotherapy, are performed on instruction from the treating doctor or on a patient's/ guardian's request. These treatments are given in accordance with the discretion of the physiotherapist.
All the necessary steps will be taken to eliminate and/or minimize any potential risks and, or disadvantages associated with any treatment. To perform certain treatments, the physiotherapist may need to uncover specific parts of the patient's body and make physical contact with him/her. This will always be carried out in a professional manner, protecting the

privacy of the patient as far as possible. It is your right as the patient to request a witness to the treatment be made available. The patient is encouraged to immediately discuss with the treating therapist if they feel their privacy or decency is being compromised or to ask why a particular technique is being used. It is inherent to the practice of physiotherapy that the patient is moved and touched and if a patient feels uncomfortable with any procedures it is the patient's duty to verbally refuse to continue with the treatment session.

Patient confidentiality will be protected at all costs, but absolute confidentiality cannot be guaranteed, and consent needs to be obtained for the following reasons:

- The physiotherapist may need to divulge personal and medical information regarding the patient to other attending practitioners and administrative staff concerned for the purposes either relating to the treatment or to process for statistical, epidemiological, managed health care and payment purposes.
- Submission of accounts to the medical scheme or a third-party payer may need personal and medical information related to your diagnosis and treatment for accounts to be processed.
- Should reports or referrals be requested, relevant health information about your diagnosis and treatment may need to be shared with other health practitioners, administrative or medical staff.
- You have the right to decide that you do not want to disclose your private health information to your medical scheme or to the other members of the Health Care Team. In this case a non-disclosure code (U98.0 - patient refused to disclose clinical information) will be used. However, when this code is used, you should be aware of the following:
    - Your medical scheme is not obliged to pay the claim/account as they need your health information (such as ICD-10 codes) to do so.
    - Your medical scheme may not pay for the services rendered and you will be liable for the account.

You have the right to withdraw any consent given or refused at any future visit. Should this occur, you will need to inform us of this decision and sign another informed consent form, indicating your amended decision. We strive to always provide you with the best professional service and treatment.

I confirm that I understand the above information and I have exercised my choice voluntarily.

I hereby accept and agree to the terms and conditions mentioned above and consent to physiotherapy treatment.

Name: (Patient/Guarantor/Guardian):	
Place:	
Date:	Signature: