

# NEETHLING STRAUSS AND ARPESELLA

REGISTERED PHYSIOTHERAPISTS

Practice Number: 072000 007 3393

## CONSENT TO TREATMENT

1. I, the undersigned, hereby confirm that I understand the proposed treatment as discussed with me.
2. I understand the nature, benefits, risks and complications of the treatment as explained to me.
3. I am satisfied that alternative forms of treatment were discussed and that I had the opportunity to ask questions.
4. I had sufficient opportunity to consider whether I want to proceed with the proposed treatment.
5. I acknowledge that I have been informed in a language understood by me.
6. I therefore freely and voluntarily agree to the treatment.
7. I hereby consent to remove any clothing deemed necessary in order to receive effective treatment.
8. I realize that the Physiotherapist might need to touch me in order to receive effective treatment.
9. I acknowledge that dry needling may be used as a modality for treatment and understand the risks involved as explained by my Physiotherapist.
10. I hereby give consent that the Physiotherapist and/or the format of treatment can change at any time and that different physiotherapy staff members may be involved in the course of treatment.

I, THE PATIENT/GAURDIAN, GIVE INFORMED CONSENT TO TREATMENT.

NAME AND SIGN:	DATE:	WITNESS:
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## ADMINISTRATIVE CONSENT

1. I, the undersigned, give consent to NEETHLING, STRAUSS AND ARPESELLA PHYSIOTHERAPISTS to divulge personal and medical information on myself to other attending practitioners for purposes either relating to my treatment or to process for statistical, epidemiology, managed health care and payment purposes, which includes the sending of an agreed upon account to the relevant third party payer if applicable. Such access to my personal medical records will be on a need to know basis.
2. I understand that my confidentiality will be protected at all costs, but that absolute confidentiality cannot be guaranteed.
3. It is further known to me that I can at any time withdraw this consent and that my personal and medical information will thereafter not be processed other than for payment purposes for treatment/services rendered/received.
4. I understand that there might be a co-payment payable for the treatments and that I am personally responsible for the payment of this account and NOT my medical aid.
5. I understand that the practice of NEETHLING, STRAUSS AND ARPESELLA PHYSIOTHERAPISTS will not get involved in any medical aid or other third party disputes.
6. I understand that the **SETTLEMENT TERMS ARE STRICTLY 30 DAYS** and will pay any shortfall within that time
7. I understand that I will be liable for all legal costs on attorney and client scale, collection charges and tracing fees, should my account be handed over for any monies in arrears.
8. I understand that all effort is taken to capture my data correctly, but errors do occur. I undertake to check my account carefully and make sure that the membership number, initials, spelling & other information on the account is correct.
9. I understand all data is sent electronically to the medical aid where applicable.
10. I acknowledge that the medical aids require diagnosis to be sent in ICD10 diagnostic format for payment of accounts and authorize as such.
11. Methods of payment can include cash, cheque, credit or debit cards.

I, THE UNDERSIGNED ACCEPT THE TERMS OF THE ADMINISTRATIVE CONSENT

NAME AND SIGN:	DATE:	WITNESS:
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I FURTHER GIVE CONSENT FOR CORRESPONDENCE VIA EMAIL OR SMS

EMAIL ADDRESS	Y/N	CELL	Y/N
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