NEW PATIENT DETAILS, ACCOUNT INFORMATION & TERMS & CONDITIONS FORM

Nicole Comninellis Inc.
Physiotherapy (for kids)

PATIENT DETAILS	**MEDICAL AID DETAILS**
First Name(s):	Main Member Name and Surname:
Surname:	
Gender: ( ) Male ( ) Female ( ) Other	Main Member ID Number:
Date of Birth:	Medical Aid:
If born preterm, no. of weeks early:	
REFERRING DOCTOR / PAEDIATRICIAN	Plan type:
Name:	Medical Aid no.:
Email/Tel:	Child Dependent Code:
FIRST PARENT'S DETAILS	**SECOND PARENT'S DETAILS**
Full Name:	Full Name:
ID Number:	ID Number:
Address:	Address:
Tel:	Tel:
Cell Phone:	Cell Phone:
Email:	Email:
Occupation/Employer:	Occupation/Employer:

PERSON RESPONSIBLE FOR THE ACCOUNT (tick or complete if different from the above)

Parent 1 ( ) Parent 2 ( ) Other* ( ) *complete below

Full Name:	DOB:
	ID number:
Home Address:	

Tel: (h)	Tel: (w)	Cell Phone:
Occupation:	Employer:	
Email Address:		

BILLING POLICY

Payment is due after the appointment and can be made via SnapScan. By arrangement, payments can be made via EFT to the banking details on the invoice. For all payments, please use your child's name and surname as a reference.

This Practice bills at the current medical aid rate for **in-hospital** and **pre-authorised out-of-hospital PMB benefits**.
Please check with your scheme about specified physiotherapy benefits

All out-of-hospital medical aid claims must be submitted by the member to their scheme directly unless otherwise arranged with the practice, and in this case any shortfalls in payment are to be settled by the client prior to any follow-up appointments.

Private rates: R750 for a first consultation of 60 minutes which includes therapeutic time; R530-R575 for 45 minutes rehabilitation; R575 for respiratory physiotherapy; R665 for 60 minutes. **School visits** can be arranged at an additional rate of R175, in addition to the session fee. **Home visits** will be billed at an additional R225. **Missed appointments** or those not cancelled within 6 hours of the appointment are billed at R350. Comprehensive reports requested will be billed at R500. PMB motivations will be billed at R225. Please note that fees will increase annually.

Please sign to accept the billing policy:

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TERMS AND CONDITIONS

CHILDREN AND HEALTHCARE

You confirm that you understand that, as a parent / legal guardian, you are legally liable to cover the cost of your / your child's healthcare, even if the Children's Act allows a child older than 12 years to provide consent to treatment without your consent. Note that the Practice will not get involved in parental disputes as to the financial aspects of healthcare provided to a child.

INFORMED CONSENT

I understand that I have the right to be informed about and ask the Physiotherapist questions pertaining to the medical condition and treatment approach, including: details or uncertainties of the diagnosis / prognosis, including the likely prognosis if the condition is left untreated; different treatment / rehabilitation options available; the benefits / risks of these treatment / rehabilitation options, as well as the costs associated with these; any specific side effects of specified treatment; how the condition will be monitored and evaluated; and that I have the right to a second opinion.

I understand that the Physiotherapist who has overall responsibility for the treatment is Nicole Comninellis, practice owner and registered Physiotherapist: HPCSA PT 0119806 and practice number 0832073. If you do not ask any questions, the Practice assumes that you have understood and accept everything.

PRICING/FEES AND PAYMENT

This Practice bills according to a billing policy as stated on page 1.

All consultations, assessment and treatment/rehabilitation fees must be paid by you and it remains your responsibility to submit the claims to your medical scheme, unless agreed upon by the practice to claim from your medical aid on your behalf.

If you have not received an account for your consultation, please let the Practice know immediately. If your account is not paid after 30 calendar days, we will give, in terms of the National Credit Act, notice of 20 working days that your account is in arrears. If you fail to settle the account within another 10 days, the account will be handed over for debt collection. Interest will be charged at 2%, as allowed by the National Credit Act, per month on all outstanding accounts.

You will also be responsible for all costs relating to the debt collecting, such as commissions and fees levied by the debt collector or attorney.

If you believe that your medical scheme should have paid in full, you can lay a complaint at the Council for Medical Schemes. If you believe that terms and conditions of the medical scheme are unfair or that the benefits were not clearly communicated, you can complain at the National Consumer Commission.

PURPOSE AND NATURE OF HEALTH CARE

You accept that results cannot be guaranteed in healthcare. Results may take time to become evident, and this is dependent on the patient's behaviour, effort and overall commitment to treatment/rehabilitation both during the sessions and after, e.g., when doing prescribed exercises at home. You agree to follow the instructions/treatment plan prescribed to you by the Physiotherapist, and attend follow-up visits if recommended to you. Should you neglect to follow the recommendations provided to you, the Physiotherapist / Practice will not be held liable for subsequent consequences.

POPI ACT: CONFIDENTIALITY, PROCESSING & DISCLOSURE OF PERSONAL AND MEDICAL INFORMATION

This document constitutes a contractual agreement by the Practice/s to protect all personal information in confidence. The privacy and security of the personal information of patients are important to us.

The Practice/s will use your and your child's information only in relation to their healthcare. Personal information that Nicole Comninellis Physiotherapists process, retain, use and disclose may include, without limitation your: age, contact information, occupational information, personal health information, medical history and any other information deemed necessary to fulfil the purposes of any of the following: physiotherapy assessment and treatment services; to provide to, or obtain from Third Party payers, Doctors, other Allied Health Professionals, and Legal Counsel progress reports, assessment findings, diagnostic tests or medical investigations resulting from the services provided to you in order to optimize the treatment provided to you. At times, the law requires the Practice/s to disclose their/your personal information, and by agreeing to our services, you acknowledge this legal obligation that the Practice/s have to disclose: 1. To your medical scheme: a diagnostic code and details of the consultation / treatment, which is used by the scheme to evaluate whether it is contained within your benefits; 2. To referring healthcare professionals involved in your care: Information that is necessary and in your best interest will be shared with such healthcare professionals in terms of the National Health Act; 3. To sharing of relevant information with bodies performing peer-review of practitioners, clinical audits or coding queries; all subject to confidentiality of records. I authorise my Physiotherapist / the Practice to: Use and disclose my child's medical information to any relevant specialist; Keep and maintain a copy of my or my child's medical record on file; and have access to hospital records, radiology & laboratory results.

Consent under the Protection of Personal Information (POPI) Act means that you voluntarily agree to the processing of your personal information during the course of treatment, including the communication of results / feedback or reports via electronic means. You understand the confidential nature of information that may be exchanged via electronic means and the risks associated thereof and agree to this communication by signing below.

PATIENT / CLIENT / CONSUMER DUTIES (NATIONAL HEALTH ACT, 2003)

You and/or your family or other persons that come to the Practice, or have a consultation at home or school, should not harass or cause harm toward the Physiotherapists. They must be treated with respect. If not, we are allowed by law to refuse to treat- or to continue to treat you or your children. In such cases we will refer you to another Practice.

INDEMNITY (WAIVER OF LIABILITY)

You accept that physiotherapy is active and may include the use of equipment which could lead to injury. You acknowledge that the physiotherapist(s) will do their best to ensure safety of your child at all times, but that your child will participate at their/your own risk, and that the practice is not responsible for children not following instructions. You indemnify the practice from any and all loss, costs, injury, damage or liability sustained or incurred by your child (or their siblings) from their participation in the therapeutic environment. You agree to mitigate any risks by ensuring your child is co-operating and following instructions, as expected by the physiotherapist.

Initial:

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AGREEMENT

I the undersigned, agree as follows:

1. I am personally responsible for payment for physiotherapy services rendered to me and/or to any child of whom I am the parent or legal guardian, in accordance with the tariff of charges, and not my medical aid.
2. I agree that I have had the opportunity to read this document and that I understand and agree to the contents contained herein.
3. I consent to the physiotherapy assessment / treatment procedures for my child by the Registered Physiotherapist. My consent is voluntary, and I intend this consent form to cover the entire course of physiotherapy with this Practice. I understand that I can withdraw my consent at any time.
4. I hereby choose my above address as my domicilium citandi et executandi for all purposes under this agreement.
5. I agree to inform the Practice of any changes to information pertaining to financial, medical or personal information, e.g., change of condition, medical aid or contact information. I agree to set-up a payment arrangement if I am having financial difficulties.
6. I agree to provide feedback, complaints or compliments as appropriate, and agree to ask any questions I should have.
7. I agree that I may be contacted by the practice, using the contact details provided.
8. I acknowledge that I can access the privacy policy online via www.thelaunchpad-kids.com
9. I confirm that the information provided by me is true and correct.

Signed _____ **Date** _____

Name _____

PHOTO/VIDEO CONSENT

For objective analysis and certain assessments which rely on qualitative review, video and photograph media are extremely beneficial in supporting therapeutic outcomes, by review of both the child in terms of continuous assessment, and therapist's treatment techniques in retrospect.

This media is only taken with your consent and will not be used in any other means apart from that of your child's medical record: assessment, response to therapeutic input, record-keeping and for training of your child's caregivers, new therapists or with your specific consent, other therapists. At times, it is beneficial to the child to discuss the images or video with colleagues or the referring doctor in order to seek their opinion or expertise. I understand that this would also be strictly confidential between all parties.

I understand that these images will remain strictly confidential and will be used purely for therapeutic assessment and monitoring of my child. I understand that my child may at times need to remove items of clothing in order to obtain an accurate image/video, but that my child will not be forced to do this, and that respect will be maintained at all times. Video media may span the length of the therapeutic session. This consent stands in an ongoing manner.

I, the undersigned hereby grant the practice of Nicole Comninellis Inc. permission to take photographic and or video media of my child, as well as any caregivers or family members who may appear within the session. I agree that I can withdraw my consent at any time.

Name of Child: _____

Name of Parent: _____

Date: _____ Signature: _____