

INFORMED CONSENT AND FINANCIAL RESPONSIBILITY FOR PHYSIOTHERAPY ACCOUNT

Ithe undersigned hereby give informed consent for physiotherapy treatment, understand and declare that:

- During the treatment and evaluation I might need to uncover specific body parts and I understand that I may refuse to do so if and when I do feel uncomfortable in doing so.
- The physiotherapist will need to touch me in order to provide effective treatment and that I will inform the physiotherapists if and when I feel uncomfortable in doing so.
- It is my right to withdraw this consent at any time or for any specific procedure or modality.
- I have been informed of all the benefits and risks of the procedures and or modalities. I have been informed of alternative procedures and modalities.
- I understand the procedures and possible potential complications and I had the opportunity to discuss this with the physiotherapist.
- I hereby consent to physiotherapy procedures and modalities that will be performed on me/ my dependant: subjected to the physiotherapist performing the relevant assessment of medical documentation, investigations and radiographic evidence, ensuring that the relevant precautions and contra-indications are taken into account.
- I give this consent freely and declare that it was not made under duress.
- I accept full financial responsibility for this account until it is settled in full.
- I understand that I will be responsible for all legal fees involved, if legal action is needed to collect any outstanding fees.
- I hereby declare all personal and financial information as true and correct.

Billing Procedures

1. This practice charges NHPRL rates as suggested by Board of Healthcare Funders. Your medical aid might not pay your account in full due to the individual medical aid funding structures.
2. We are not contracted with Discovery Health. Outpatient Discovery Health patients and those administered by Discovery Health are responsible for their own accounts and must be settled after each treatment.
3. Other Medical Aids' claims will be submitted electronically to the various medical aids at a cost to the practice.
4. The outstanding amount on the patient's account is their sole responsibility and has to be paid within 30 days.
5. Interest at 15.5% per annum will be charged for accounts outstanding after 30 days of the first treatment date.

I hereby declare that the billing procedures of this practice have been discussed with me and that I do understand the conditions and implications thereof. I declare that this consent was not made under duress.

.....
Patient

.....
Date