ALBRIE LABUSCHAGNE
BIOKINETICS

PRACTICE NO: 0208558

TEL: +27 82 332 9929. | **EMAIL:** albrielab@gmail.com

Address: Curro Bakenveld High School Premises, Silverlaan, Reyno Ridge, Withbank

1 CONSENT TO BIOKINETIC TREATMENT BY *ALBRIE LABUSCHAGNE BIOKINETICS*.

(MUST BE SIGNED BY ALL PATIENTS OLDER THAN 12 YEARS)

I, _____, the undersigned, 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 biokineticist may need to touch me in order to provide effective treatment and that I will inform the biokineticist if and when I feel uncomfortable.
- It is my right to withdraw this consent at any time or for any specific treatment or intervention.
- I have been informed of all the benefits and risks of the treatment and or intervention. I have been informed of alternative treatment or intervention
- I understand the treatment and potential complications and I had the opportunity to discuss this with the biokineticist.
- I further more grant any employee of ALBRIE LABUSCHAGNE BIOKINETICS permission to arrange for the necessary medical assistance that may be required in case of injury or damage, should I be unable to do so myself.
- I hereby consent to biokinetic treatment and interventions that will be performed on me / my dependant: subject to the biokineticist performing the relevant safety tests and evaluation, and taking relevant precautions.
- I have disclosed all my medical conditions, medications, and any other related information to the biokineticist.
- I understand that all information given to the biokineticist will be treated with the utmost confidentiality.
- I have been informed that the practice is accredited with the HPCSA as a training facility for students in Biokinetics. Service might therefore be rendered by Biokinetic students or interns.
- I give this consent freely and declare that it was not made under duress.

_____ **Date:**_____/_____/_____

SIGNED: PATIENT / GUARDIAN IF PATIENT IS YOUNGER THAN 12

BIOKINETICS SA
LIFE THROUGH MOVEMENT

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2 CONSENT TO THE RELEASE OF INFORMATION BY *ALBRIE LABUSCHAGNE BIOKINETICS*

(*MUST BE SIGNED BY ALL PATIENTS OLDER THAN 12 YEARS)*

I, _____, the undersigned, do hereby give consent to **ALBRIE LABUSCHAGNE BIOKINETICS** to disclose information regarding my diagnosis (ICD 10 Coding), medical condition, prognosis, treatment compliance, and treatment program to the following people / institutions for the purpose of reimbursement or settlement of his / her account, and or for referral and reporting purposes:

Please initial the boxes that you do give consent to:

	YES	NO		YES	NO
Medical Scheme /Funder:	☐	☐	Referring Doctor:	☐	☐
Employer:	☐	☐	Lawyer:	☐	☐
School / Coach:	☐	☐	Other medical practitioners:	☐	☐
Parents:	☐	☐	Spouse:	☐	☐
Children:	☐	☐	Insurance Company:	☐	☐
Other: _____	☐	☐	Comp-solve (Only Injury on Duty):	☐	☐

I fully understand that this is a legal requirement and that I have a choice not to consent to such information being disclosed to any party. I confirm that I have exercised my choice voluntarily and that this declaration and exercise of my choices was not made under duress.

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I indemnify **ALBRIE LABUSCHAGNE BIOKINETICS** from any liability, damages or whatsoever that I may suffer as a result of this disclosure and that I will hold this practice and its staff blameless of any further disclosures and or prejudice I may suffer as a result of such disclosures.

_____ **Date:** _____ /_____/_____

SIGNED: PATIENT / GUARDIAN IF PATIENT IS YOUNGER THAN 12.

3 CONSENT TO FINANCIAL RESPONSIBILITY OF ALBRIE LABUSCHAGNE BIOKINETICS

- I, _____, the undersigned, hereby 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.
- Appointments not cancelled 24 hours before the time of appointment will be charged.
- This is a cash practice and treatments must be paid at time of consultation, unless otherwise arranged.
- Accounts will be rendered electronically, directly to you, or printed at time of consultation. Please check all information and notify us as soon as possible of any changes or discrepancies.
- Patients who do not provide their full and correct details will have to insert these on the invoice / statement received, before submitting it to their medical aid.
- It is the patient's responsibility to clarify and rectify any mistakes made by the medical aid with the medical aid.
- Private fees are charged in accordance to medical aid rates.
- Accounts older than 30 days will be followed up with a telephone call, sms or e-mail.
- Accounts older than 60 days will receive a final written warning.

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- If still not settled within 14 days after the final warning date, the account will be handed over for legal action.
- Injury on duty patients must provide the necessary documentation within 10 days after the starting date of the treatment. Failure to do so will make the patient liable for the full account.

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.

_____ **Date:____/____/_____**

SIGNED: PERSON ACCOUNTABLE FOR ACCOUNT