



# Danielle Roux

BSc Physiotherapy (UWC)  
Registered Physiotherapist  
Practice No: 0614424

☎ 021 702 1320  
☎ 083 502 9484  
✉ dee@drphysio.co.za  
🌐 www.drphysio.co.za

Please complete form in print block letters in order to ensure legibility

DATE: \_\_\_\_\_

PATIENT ID NUMBER:

PATIENT SURNAME:

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PATIENT FULL NAMES:

PATIENT EMAIL ADDRESS:

DATE OF BIRTH: \_\_\_\_\_

TEL (W): \_\_\_\_\_

MALE/FEMALE: \_\_\_\_\_

TEL (H): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CELL: \_\_\_\_\_

POSTAL CODE: \_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_

MEDICAL AID OR PRIVATE: \_\_\_\_\_

## PAYMENT DETAILS FOR ACCOUNT HOLDER/MAIN MEMBER:

SURNAME: \_\_\_\_\_

MED AID NUMBER: \_\_\_\_\_

FIRST NAMES: \_\_\_\_\_

DEPENDENT CODE: \_\_\_\_\_

ACCOUNT HOLDER ID NUMBER:

HOSPITAL PLAN ONLY: YES/NO

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EMAIL ADDRESS: \_\_\_\_\_

TEL (W): \_\_\_\_\_

MED AID SCHEME: \_\_\_\_\_

TEL (H): \_\_\_\_\_

MED AID PLAN: \_\_\_\_\_

CELL: \_\_\_\_\_

## EMERGENCY CONTACT DETAILS:

NAME: \_\_\_\_\_

TEL (W): \_\_\_\_\_

SURNAME: \_\_\_\_\_

TEL (H): \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

CELL: \_\_\_\_\_

**\*ALL APPOINTMENTS CANCELLED LESS THAN 24 HOURS BEFORE THE APPOINTMENT TIME WILL BE CHARGED FOR AND THE PATIENT WILL BE HELD PERSONALLY LIABLE FOR ALL UNKEPT APPOINTMENTS. APPOINTMENTS ARE TO BE CANCELLED TELEPHONICALLY\***

Physical address

📍 5D Steenberg Business Park, Military Road, Steenberg, 7945

Postal address

📍 Suite 7, Private Bag X12, Tokai, 7966

**Danielle Roux**

HPCSA No: PT 0107441  
Practice No: 0614424



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ADULTS 18 YEARS OF AGE AND OLDER AND OF SOUND MIND

## CONSENT TO TREATMENT

- The purpose of physiotherapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures including but not limited to; mobilization, massage, exercises, and physical agents to aid me in achieving my maximum potential within their capabilities and to accelerate recovery and improvement in function. All procedures will be thoroughly explained to me before I am asked to agree to undergo the recommended treatment.
- The physiotherapist will speak to me about my **health status**, i.e. how my health appears to be, or how s/he has evaluated my health, condition or injury. If another healthcare practitioner (doctor, therapist, etc.) has referred me to the healthcare professional, this referral will be discussed with me. I will be required to explain my condition to the physiotherapist in my own words according to my understanding.
- In order to perform certain treatments effectively the Physiotherapist may need to expose specific parts of my body and treat that area. This will at all times be completed in a professional manner and privacy will be respected at all times.
- I understand that my treatment will require participation and a commitment from me. I understand that, specifically. I have to consider the following, but not limited to: (*e.g. treatment duration, coming back to the Practice as instructed, doing exercises or following other instructions, etc.*)
- I understand that I can **refuse** health care at any stage, but also understand that if I refuse, the physiotherapist must explain the **consequences of the refusal** to me. I will then not hold the physiotherapist liable for any of those consequences, should they happen. If I refuse, I must still pay for the health care I have had up to the point of refusal.
- Tariffs will be charged according to the guidelines of the South African Society of Physiotherapy, unless otherwise stipulated. All cash paying patients are to settle on conclusion of their treatment. All accounts to be settled within 30 days from the date of account. I remain personally responsible for payment of my account and not my medical aid. My medical aid may not settle the full amount of the account. Interest will be charged on outstanding amounts as stipulated by the HPCSA on accounts not settled after 60 days. Should the debt be handed over for collection all costs incurred will be added to my account.
- All appointments not cancelled telephonically **AT LEAST 24 HOURS BEFORE** the appointment time will be charged **A LATE CANCELLATION FEE**, which is to be paid for by me (Initial: \_\_\_\_\_)

Signed at \_\_\_\_\_ (place) on \_\_\_\_\_ (date)

Patient Full Names: \_\_\_\_\_ Signature: \_\_\_\_\_

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## CONSENT TO SHARING OF PERSONAL INFORMATION

- The privacy and security of the personal information of patients (who include any person who may consent or contract on behalf of a patient) is important to us. We will only process personal information, which includes: collect, use, store and share such information, in accordance with the Privacy Statement of the practice. A copy of the practice's Privacy Statement can be made available on request by the patient.
- The practice must include ICD-10 codes on accounts that disclose the patient's diagnosis and are a standard operating procedure of this practice. These codes are necessary for funding decisions and benefit allocations by funders such as; the patient's medical scheme, the Compensation Commissioner for Occupational Injuries and Diseases, and the Road Accident Fund.

*I consent to the following specific processing activities of my personal information by the practice:*

- The submission of my accounts to my medical scheme / other funder;
- The submission of information relevant to my diagnosis and treatment to my medical scheme / other funder, if required;
- The inclusion of relevant health information in referral letters and when providing reports about my treatment to referring practitioners;
- To sharing of relevant information with bodies performing peer review of practitioners or clinical practice audits, subject to confidentiality undertakings.

*I confirm that I provide consent of my own free will without any undue influence from any person whatsoever. I have received all the information required to provide consent.*

Signed at \_\_\_\_\_ (place) on \_\_\_\_\_ (date)

Patient Full Names: \_\_\_\_\_ Signature: \_\_\_\_\_

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