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JEANNE MARAIS PHYSIOTHERAPY
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THIS DOCUMENT CAN BE COMPLETED
DIGITALLY IF THAT IS YOUR PREFERENCE

ACCOUNT RESPONSIBILITY

Full Name		ID Number
Residential Address		Code
Postal Address		Code
E-mail Address (for statements)		
Work Tel	Home Tel	Cell

MEDICAL SCHEME

Medical Scheme Name	Membership Number	Patient's Dependent Code
Main Member's Name		Main Member ID
Work Tel	Home Tel	Cell

PATIENT DETAILS

Full Names	Pronouns	Title	Marital Status
ID Number		Preferred Name	
Date of Birth / Age / Occupation		Language	
E-mail Address (patient-specific)		Cell	

EMERGENCY CONTACT

Name	Relationship	Tel

REFERRED BY

Name	Relationship	Tel

WHERE DID YOU HEAR ABOUT US?

☐ Google Maps ☐ Google Ads ☐ Email Article ☐ Facebook Recommendation ☐ Facebook Ads ☐ Building Signage

☐ Word of mouth (Please specify)_____ ☐ Other (Please specify) _____

IMPORTANT FOR PATIENTS TO NOTE - GENERAL TREATMENT

Exercises: You may be given exercises to do during the treatments (or as a home program) which are commonly used to relieve or prevent pain. If you find any exercise(s) progressively painful, it is your responsibility to stop doing that exercise and to seek clarification from your therapist.

Strapping: Your therapist may apply strapping during your treatments. People may however, unknowingly, be allergic to certain forms of strapping and therefore it is important to look out for the signs and symptoms which may indicate such an allergy. These may include burning and itching sensations and redness around the area. In severe cases the area may become weepy, oozy or swollen. Please remove the strapping if you suspect an allergic reaction and consult your doctor / pharmacist on the best treatment thereof. Be cautious with future strapping and inform your therapist if you have had a reaction.

Oil/ Skin sterilizer allergies: These allergies may present the same as the strapping. Please consult your doctor / pharmacist on the best treatment thereof, be cautious with future treatments and inform your therapist if you have had a reaction.

Electrotherapy: Certain electrotherapy modalities may cause adverse reactions and are therefore contra-indicated in some conditions. Please inform the therapist in advance if any of these are applicable to you or if you suspect that they might be: **Pregnancy, Malignancy (Cancer), Active implants (e.g., pacemaker), Metal implants, Circulatory problems, Epilepsy, Active bleeding.**

Hot / Cold therapy: The intention is not to burn your skin. Please remove the pack immediately and inform your therapist if a hot / cold pack is burning you.

During treatments: The treatments may at times be painful / uncomfortable but isn't ever intended to be unbearable. Should you experience unbearable pain, you need to communicate this to us immediately. During any manual treatment it is important that you remain still and relaxed, to minimize the risk of unnecessary pain / complications (especially with Dry Needling). Please let your therapist know if you are uncomfortable, experiencing too much pain or if there is anything you are unsure of.

After treatments: The treated area(s) may be tender for a day or two, and after manual treatments there may at times be some bruising. This is normal, it should ease off quickly and the home exercise program usually aids in its resolution.

Neurological signs: Inform your therapist with immediate effect if you experience any of the following during or as a result of any treatment (be that in the rooms or during your prescribed self-treatments): **Dizziness, Ringing in the ear(s), Nausea, Blurred vision, Slurred speech, Genital numbness / tingling, Incontinence, Difficulty urinating or defaecating**.

Only children under 12 years of age may have a parent / guardian consent to medical assessments / treatments on their behalf.
Those 12 years and over need to consent themselves.

Patient (or guardian): _____

Account Responsibility: _____

This page does not form part of the agreement between the practice and any person noted on page 1. This page MUST be completed by the patient alone and caries no value if any other person is involved in answering this page. Please leave it blank if the above is not possible for whatever reason.

Date: _____

The Keele STarT MSK Tool © Self-report version

For questions 1-9, think only about the past 2 weeks:

1) On average, how intense was your pain [where 0 is "*no pain*" and 10 is "*as bad as it could be*"]

○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

	No	Yes
2) Do you often feel unsure about how to manage your pain condition?	◉	○
3) Over the last two weeks, have you been bothered a lot by your pain?	◉	○
4) Have you only been able to walk short distances because of your pain?	◉	○
5) Have you had troublesome joint and muscle pain in more than one part of your body?	◉	○
6) Do you think your condition will last a long time?	◉	○
7) Do you have other important health problems?	◉	○
8) Has pain made you feel down or depressed in the last two weeks?	◉	○
9) Do you feel it is unsafe for a person with a condition like yours to be physically active?	◉	○
10) Have you had your current pain problem for six months or more?	◉	○

CSI **Please mark the appropriate block for each statement**

		Never	Rarely	Sometimes	Often	Always
1	I feel tired and unrefreshed when I wake from sleeping	▣	☐	☐	☐	☐
2	My muscles feel stiff and achy	▣	☐	☐	☐	☐
3	I have anxiety attacks	▣	☐	☐	☐	☐
4	I grind or clench my teeth	▣	☐	☐	☐	☐
5	I have problems with diarrhoea and/or constipation	▣	☐	☐	☐	☐
6	I need help in performing my daily activities	▣	☐	☐	☐	☐
7	I am sensitive to bright lights	▣	☐	☐	☐	☐
8	I get tired very easily when I am physically active	▣	☐	☐	☐	☐
9	I feel pain all over my body	▣	☐	☐	☐	☐
10	I have headaches	▣	☐	☐	☐	☐
11	I feel discomfort in my bladder and/or burning when I urinate	▣	☐	☐	☐	☐
12	I do not sleep well	▣	☐	☐	☐	☐
13	I have difficulty concentrating	▣	☐	☐	☐	☐
14	I have skin problems such as dryness, itchiness or rashes	▣	☐	☐	☐	☐
15	Stress makes my physical symptoms get worse	▣	☐	☐	☐	☐
16	I feel sad or depressed	▣	☐	☐	☐	☐
17	I have low energy	▣	☐	☐	☐	☐
18	I have muscle tension in my neck and shoulders	▣	☐	☐	☐	☐
19	I have pain in my jaw	▣	☐	☐	☐	☐
20	Certain smells such as perfumes, make me feel dizzy and nauseated	▣	☐	☐	☐	☐
21	I have to urinate frequently	▣	☐	☐	☐	☐
22	My legs feel uncomfortable and restless when I am trying to go to sleep at night	▣	☐	☐	☐	☐
23	I have difficulty remembering things	▣	☐	☐	☐	☐
24	I suffered trauma as a child	▣	☐	☐	☐	☐
25	I have pain in my pelvic area	▣	☐	☐	☐	☐

List of chronic medication: _____

_____

_____

_____

_____

_____

_____

_____

Recent non-chronic medication: _____

_____

_____

PRIVACY STATEMENT

A reference to the patient, includes any person who may consent or contract on behalf of a patient, and includes the person responsible for payment of the patient's accounts.

(a) Confidentiality of Patients' Personal information: The privacy and security of the personal information of patients are important to us.
(b) What is Personal Information? Personal information is defined in the Protection of Personal Information Act [POPIA] and includes information such as the contact details, age, gender, medical scheme membership and health information.
(c) Collection of Patients' Personal Information: Personal information will be collected as far as possible from the patient, but may also be collected from the hospital/facility admission form, other treating practitioners, the patient's next-of-kin and any other source from which the practice may lawfully collect information (e.g. the public domain / public records), as may be required in the circumstances.
(d) Processing of Patients' Personal Information: The practice will only process, which includes collect, use, store and disseminate, the patient and any other relevant person's personal information in accordance with the law (e.g. the National Health Act, the Medical Schemes Act, the Health Professions Act and POPIA). The personal information of the patient will be used as follows: (i) to provide him/her with appropriate care; (ii) to communicate with him/her in respect of his/her care, including reminding the patient of appointments and collecting payments for services rendered; (iii) for administrative purposes, including preparing invoices and collecting payment for services rendered; (iv) to refer the patient to other practitioners; (v) to report to referring practitioners;
(vi) for participation in clinical trials, if applicable; (vii) record-keeping; (viii) for historical, statistical and research purposes; (ix) as proof; (x) for enforcement of the practice's rights; (xi) for any other lawful purpose related to the activities of a private physiotherapy practice; and/or (xii) as may be requested or authorised by the patient.
(e) Records of Patients' Personal Information: All personal information will be recorded in the patient's medical record, which may be held electronically, and which will be retained for such periods as may be prescribed by or permitted in terms of the law and for lawful purposes.
(f) Security: The practice has implemented mechanisms to ensure that adequate security measures are in place to ensure that personal information will be kept confidential and protected against destruction and unauthorised access. The practice will inform the patient and the Information Regulator, if any person has unlawfully obtained access to his/her personal information, subject to the provisions of the law.
(g) Sharing of Patients' Personal Information: The personal information collected before, during and after the provision of the medical services, including full details related to the diagnosis and treatment of the patient (in the form of ICD-10 codes or otherwise), will be shared, as may be appropriate, with other practitioners involved in the patient's treatment and care, and other persons who may lawfully obtain access to this information such as the patient's medical scheme, treating practitioners, the patient's next-of-kin, debt collectors, credit bureaus, regulatory bodies, other public bodies, persons and bodies performing peer review, law enforcement structures and purchasers of the practice. The practice will obtain the patient's consent for such disclosures, at all times. Staff members as well as service providers and professional advisers of the practice will obtain access to the information, subject to confidentiality undertakings, and strictly on a need-to-know basis, to provide services and/or advice to the practice. Personal information will not be disclosed by the practice to any person other than those indicated on this form or without the patient's consent unless authorised in terms of the law. If we must provide the patient's personal information to any third party in another country, we will obtain prior consent unless the practice may lawfully do so.
(h) Diagnosis / ICD-10 Codes: The practice must include codes on accounts that disclose the patient's diagnosis, known as ICD-10 codes. 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) Peer Review: The practitioners may be subjected to peer review from time to time. Bodies performing such peer reviews may need to obtain access to clinical patient information for this purpose. Such bodies will only use the information for the specified purposes and be required to sign confidentiality undertakings before access is granted, should it not be possible to anonymise the records completely.
(j) Access to Patients' Personal Information: The patient may have access to his/her personal information held by the practice and may request corrections to it, if required, subject to the provisions of the law. Please enquire at reception and complete the prescribed form. The process is also described in the PAIA (Protection of personal Information Act) Manual of the practice, obtainable from reception or on the practice's website.
(k) Withdrawal of Consent and Objection to Processing: Where consent is provided for the processing of personal information, it may be withdrawn at any time. Depending on the circumstances, this may impact on the patient's continued treatment unless the practice may process the information in terms of the law. If the circumstances make it reasonable and lawful to do so, the practice may terminate its relationship with you. In certain instances, the patient may object to the processing of his/her personal information, if it is reasonable to do so, unless the practice may do so in terms of the law. The objection must be lodged on the prescribed form. Depending on the circumstances, this may impact on the patient's continued treatment unless the practice may process the information in terms of the law. If the circumstances make it reasonable and lawful to do so, the practice may terminate its relationship with you.
(l) Accurate and up-to-date Information: It is important that the patient provides accurate information to the practice about his/her/the patient's health status, medical history and other personal details such as a valid e-mail address and mobile number as well as medical scheme membership / other funder information to facilitate appropriate treatment and care of the patient, communication with the patient and payment of accounts. It is the patient's responsibility to inform the practice if any of the information has changed.
(m) Concerns about the Processing of Patients' Personal Information: Should the patient or any other person have any concern or question about the processing of their personal information by the practice, please raise this with any of the treating practitioners or the Information Officer of the practice. A complaint may also be lodged with the Information Regulator (+27 (0) 10 023 5207 / +27 (0) 82 746 4173 or complaints.IR@justice.gov.za).

Only children under 12 years of age may have a parent / guardian consent to medical assessments / treatments on their behalf.
Those 12 years and over need to consent themselves.

Patient (or guardian): _____

Account Responsibility: _____

PRACTICE POLICIES & CONSENT

1. The person signing this file (even if only on behalf of the person deemed responsible on the 1st page) accepts full responsibility for the account - regardless of who the main member is on the patient's medical scheme.
2. A once off **R 50** admin fee will be added to the first treatment account for all new patients.
3. We endeavour, but can't guarantee, to charge rates near that of the major medical schemes.
4. It is your responsibility to confirm if your medical scheme rules and your individual policy provides cover for the required treatment.
5. The account must be settled immediately following each appointment - before leaving the practice. You may choose to do so in cash or by VISA / Mastercard.
6. You will be issued a statement after paying for the appointment, which you can submit to your medical scheme to request a refund.
7. Barring administrative errors on your account, the practice will not be held responsible for non-refunds from your medical scheme for any reason whatsoever.
8. New patients will be booked for a 60min session to allow for a comprehensive evaluation. This duration normally allows for treatment within the initial appointment time but on rare occasions, the assessment can be more time consuming and therefore, treatment during the initial appointment cannot be guaranteed.
9. Initial assessment and treatment appointments average at **R 850** / appointment.
10. Follow-up sessions up to 30minutes are unlikely to exceed **R 650** / appointment.
11. Additional time spent on complex or combination conditions are unlikely to exceed an additional **R 180** / 15minutes.
12. Home visits, Emergency and After-hours appointments will incur additional charges which are not always refunded by the various medical schemes. Should this be a concern you, kindly inquire about the current rates prior to the appointment(s).
13. Prices above are correct at the time of opening this file but are subject to change from time to time (typically once a year).
14. Any consumables (needles, strapping etc.) used during treatments will be charged over and above the treatment fees.
15. Outstanding accounts for any reason whatsoever will be charged at an additional 2% interest per month after the 1st 30 days.
16. In the event of failure to settle the account within 6 months, you may be handed over for debt collection and all additional costs will be added to the account.
17. **Cancellation Policy:** In the event of late cancellation or non-cancellation, a cancellation fee will be charged at the sole discretion of the practice and will be due immediately upon invoice. At present, **R 330** for a 30 minute appointment, **R 650** for a 60 minute appointment. To avoid these charges, kindly notify us at least 2 hours prior to the scheduled appointment time, should you wish to cancel / reschedule.
18. Any payments having to be refunded to patients / account holders for any reason whatsoever will only be done after full confirmation from our bank that such funds have cleared into the practice bank account.

POPIA

☐ I confirm that I had an adequate opportunity to read the Privacy Statement (or that the contents thereof have been explained to me in a language that I understand) and that I fully understand my rights in respect of my information held by the practice and how the practice will process my personal information. I declare that all my questions have been answered satisfactorily. I understand how the practice will process my personal information and with whom it will be shared.

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

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 *(subject to special arrangement with the practice);
- ☐ the submission of information relevant to my diagnosis and treatment to my medical scheme / other funder, if required, excluding clinical notes;
- ☐ 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, subject to confidentiality undertakings.
- ☐ the discussion of my condition, (and sharing relevant results of tests and investigations) with other health professionals who are currently (or possibly in future), involved in taking care of my health. If need be, I will specifically instruct my therapist in writing to refrain from sharing any particular matter in this regard.

☐ My consent must be sought before the practice may release any of my clinical notes to anybody whatsoever, other than myself.

☐ I consent that the practice may infrequently share information on various conditions with me and I understand that I may opt out from receiving such marketing communications at any time.

☐ I declare that I may legally provide consent relating to the patient referenced on page 1.

By signing below
- as patient, I _____ confirm that:
- as responsible person for the account, I _____ confirm that:

1. I have read and understood all the treatment information (page 1) and I am able to make an informed decision about my treatment needs and preferences.
2. I have read, understood and accepted the Privacy statement, POPIA consent, practice policies and legal consent.
3. I understand that I am required to ask about any aspects of this file, my proposed assessments and treatments which I am unsure of, or not comfortable with, and only sign below once these have been addressed to my satisfaction.
4. I give permission to the physiotherapist to do an assessment and treatment. I will ask anything I am not sure about and I expect the physiotherapist to explain my diagnosis and treatment to me.
5. I will bring to the therapist's attention, those treatment modalities which I am not comfortable with, to ensure that these treatments are avoided.
6. I understand that I may withdraw my consent to any treatment modality in future, even after previously having given consent and having received such treatment.
7. I will inform my therapist of any (medical or other) condition / situation that he / she may need to know about in order to treat me while minimizing possible complications.
8. I understand that all treatments are performed within a rehabilitative framework and that I must follow the instructions as given by the therapist to receive the full benefit of the treatment.
9. I know that it is my right to seek alternative opinions and / or treatments and I will notify the practice should I do so.
10. Should I have concerns / complaints relating to the assessment, treatment, advice or billing of this practice. I will exhaust my options through first making contact with Jeanne Marais Physiotherapy, then The South African Society of Physiotherapy Peer Review, and finally The Health Professions Council of South Africa.
11. The practice may follow up on my progress after treatment to ensure that I get the full benefit of my treatment and remain motivated during my rehabilitation process.
12. I give permission for the practice to retain my medical records, contact details, etc for the statutory requirement and will allow for a 12-month administrative period thereafter to discard appropriately of such records.

Please sign in full:

Patient (or guardian): _____ Date:_____

Account responsibility: _____ Date:_____