Healthcare Professional
Informed Consent Form for Assessment and Treatment

I hereby give my voluntary consent to receive health or related services from

Balance Sport & Wellness

Where I am consenting to therapy / treatment / procedures on behalf of someone other than myself (such as a minor / incapacitated person), I confirm that I am authorised to give such consent on their behalf as parent / guardian / curator. INITIAL

Clinical Examinations and Tests

I understand that the primary goal is to help improve my health status.

In order to proceed with an effective therapy / treatment / procedures, my health status, biological or physiological dysfunction, symptoms, and functional impairment must be evaluated by means of an interview and/or the performance of clinical examinations or diagnostic procedures or tests and I hereby consent to such examination. INITIAL

I am aware that anyone of my choosing may be present during the consultation or physical examination.

I will notify this practice of any pre-existing diseases, allergies or medical conditions which I know of, or if I am pregnant, become pregnant or am trying to get pregnant at the time of having therapy / treatment / procedures. INITIAL

Therapy / Treatment / Procedure Benefits, Risks and Alternatives

I understand that the practitioner treating me cannot guarantee the outcome or success of the therapy / treatment / procedures. The length and duration of therapy / treatment/procedures may differ from person to person.

I understand that the practitioner will discuss my therapy / treatment / procedures options with me, the purpose of the therapy /treatment/procedure, the benefits and risks (complications or side effects) of same, whether alternative therapy / treatment /procedure is/are available to me and what the benefits and risks (complications or side effects) of those alternatives are, to allow me to come to my own decision regarding whether to have the proposed therapy / treatment / procedures. INITIAL

I confirm that I have been informed of and understand the assessment and recommended therapy / treatment / procedures. If I am not satisfied with the explanation and do not wish to continue with any therapy / treatment / procedure, I will first discuss this with the practitioner treating me to work together in discussing my health in the absence of the treatment. INITIAL

I intend for this consent to apply to all therapies / treatments / procedures while I am a patient of this practice, however, should it occur that my health status changes during the course of any therapy / treatment/ procedure, I will be guided by the practitioner and actively participate in any decision affecting my health and further management thereof. INITIAL

I understand that, as with any health care services, there are risks and side effects that may arise during therapies or treatments such as tiredness, dizziness, nausea, fainting, bruising, bleeding, skin reactions, burning, increased pain, mild to moderate discomfort or injury and in the case of transcutaneous intervention procedures, infection or induced pneumothorax, numbness, sweating or shortness of breath.

Should I experience any side effects, I confirm that I will immediately notify this practice and will discuss this with the practitioner treating me. My failure to do so shall be construed as to mean that I am satisfied with the services provided and have not experienced any side effects. INITIAL

Disclosure of Health Records

I understand that health records include among other things Personal (identifying) particulars of the patient, test results, imaging investigation results, audio visual records such as photographs, videos and tape-recordings; clinical research and other forms completed during the health interaction such as insurance forms, disability assessments and documentation of injury on duty.

I also understand that in order for the practitioner to claim from my medical aid scheme, certain information relating to my diagnosis will have to be shared with my medical scheme. If this information is not shared, then my medical scheme will not honour my claim.

I also understand that the practitioner may be under a duty to disclose some of my health records with other parties.

I consent to my health information/diagnosis being shared with:

Party			Purpose
Other health professionals	YES ☐	NO ☐	Involved in management of my treatment
Legal matter	YES ☐	NO ☐	As part of any legal issue between the patient and practitioner
Employer / potential employer	YES ☐	NO ☐	Employment related matter
Family / family member / partner	YES ☐	NO ☐	
Research	YES ☐	NO ☐	Teaching/ training provided I remain anonymous in any journal or publication
Other (specify)			

Patient / Practitioner Confidentiality Towards Health Information and Records

I am aware that practitioners and patients have rights and responsibilities in terms of the National Patient Rights Charter and the Constitution of South Africa.
I am aware of the risks involved in the sharing of information via social media, even if the consequences are unintended.
I confirm that I will respect the practitioner and other patients by not using social media as a platform to make any speculations about the practitioner or the therapies or treatments received. INITIAL

Fees

I confirm that I have supplied all personal and employment details to the practitioner for purposes of addressing and billing me correctly.

I have been informed of the costs of the therapy / treatment / procedure before commencement of same. I will also be entitled to a fee breakdown even if the fees are paid by medical aid.

Where I **have no** medical aid, the fees are due and payable immediately on completion of the service.

Where I **have** medical aid, I understand that I might not be fully reimbursed by my medical aid and I am responsible for claiming my refund from my medical aid.

Should I not cancel an appointment one day ahead of the scheduled therapy / treatment / procedure, I may be invoiced for the missed consultation.

Please note that if payment is not made within 90 days, the account will be handed over to attorneys for collections. I agree that the practitioner shall be entitled to charge me all legal costs and disbursements incurred by the practitioner in connection with the appointment of any agents and / or attorneys to recover any amount owing by me. INITIAL

Withdrawal of Consent

I am hereby made aware of my right to withdraw my consent at any time for any therapy / treatment / procedure. INITIAL

Disclaimer Notice / Indemnity

I confirm I have entered this practice and use all equipment at my own risk. The practitioner, its agent/s and/or its employee/s shall not be liable for theft of personal items including vehicles parked on premises, injury, loss or damage of whatever nature. INITIAL

Patient / Parent / Guardian / Curator (delete whichever is not applicable):

Name: _____

Signature: _____ Date: _____

Person Responsible for the Account

Name: _____

Signature: _____ Date: _____

Withdrawal of Consent

I hereby withdraw my consent for the further undermentioned therapy or treatment of me or

_____

I have been explained that by discontinuing this therapy or treatment, there might be, implications, risks and obligations for my health. The practitioner has explained such implications, risks and obligations to me. I have considered these implications, risks and obligations, and herewith confirm my decision to discontinue.

Patient / Parent / Guardian / Curator (delete whichever is not applicable):

Name: _____

Signature: _____ _____