BALANCE
sport & wellness

CHIROPRACTIC
Dr Helen Schlebusch

***Practice No**. 0261599*

PHYSIOTHERAPY
Claudia Lepera
Melody Fitch
***Practice No**. 0474401*

PER NO.: _____ ACC NO.: _____

PATIENT DETAILS:

TITLE: _____ FIRST NAMES: _____ SURNAME: _____

I.D. NUMBER / DATE OF BIRTH: _____

HOW DID YOU HEAR ABOUT US: _____

GENERAL PRACTITIONER / SURGEON: _____

EMPLOYERS NAME: _____

EMPLOYERS ADDRESS: _____

HOME ADDRESS: _____

_____

TELEPHONE HOME: _____ WORK: _____

CELL: _____ EMAIL: _____

(If Not Patient) PERSON RESPONSIBLE FOR ACCOUNT

TITLE: _____ FIRST NAMES: _____ SURNAME: _____

ID NO.: _____

HOME ADDRESS: _____

TELEPHONE HOME: _____ WORK: _____

CELL: _____ EMAIL: _____

MAIN MEMBER & MEDICAL AID DETAILS

TITLE: _____ FIRST NAMES: _____ SURNAME: _____

ID NO.: _____ **BENEFICIARY NO of Patient.** (Eg. 00/01/02) _____

MEDICAL AID NAME: _____ MED AID NO.: _____

TELEPHONE HOME: _____ WORK: _____

CELL: _____ EMAIL: _____

PLEASE INDICATE BY TICKING BELOW, HOW YOU WILL BE PAYING FOR YOUR TREATMENTS:

MEDICAL AID ☐ CASH / CARD ☐

I, the undersigned, hereby give consent to the following:
To pay interest at the maximum monthly rate as laid down by the Limitation and Disclosure of Finances Charges Act from the first day of each month on all overdue accounts.
To pay all Attorney and Client costs, collection commission and tracing costs if my account is handed over to an Attorney to collect as a result of my default.
I also choose the address reflected above as my chosen Domicilium Citandi et Executandi.

ALTHOUGH THIS PRACTICE IS CONTRACTED INTO MEDICAL AID, THE ACCOUNT IS OF THE PATIENT'S RESPONSIBILITY IF THE MEDICAL AID DOES NOT SETTLE THE OUTSTANDING AMOUNT.
A DISCOUNT IS OFFERED IF PAID ON THE DAY OF CONSULTATION.

PLEASE NOTE: APPOINTMENTS NEED TO BE CANCELLED 24 HOURS IN ADVANCE.

SIGNED: _____ **DATE:** _____

CONSENT FOR CHIROPRACTIC OR PHYSIOTHERAPY TREATEMENT

I, _____ **ID no:** _____, knowingly and willingly consent for myself **or** for a minor child _____, under my care, to receive elective Chiropractic or Physiotherapy treatment from (insert Name of Therapist) _____ and/or their associate.

1.1 I understand, as in the practice of medicine and other health disciplines, the practice of chiropractic and physiotherapy may also present some risk, including but not limited to, sprain, strain, fractures, dislocations and general aggravations of an inflammatory nature.

1.2 I understand that the chiropractor OR physiotherapist will examine and evaluate my condition in order to minimize any risk. I do not expect the chiropractor OR physiotherapist to be able to anticipate and explain all risks and complications and I therefore wish to rely on the chiropractor OR physiotherapist to exercise their judgement during the course of such procedures, based upon the facts then known, and considered in my best interest.

1.3 I understand that I will have an opportunity to discuss with the chiropractor OR physiotherapist OR the nature and purpose of the procedures I will receive.

2 I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. Chiropractic and Physiotherapy procedures/treatment take place with the patient in very close proximity to the practitioner. This potentially exposes the patient and the practitioner to the COVID-19 virus.

2.1 I understand that due to the frequency of visits of other Chiropractic and Physiotherapy patients, the characteristics of the COVID-19 virus, and the characteristics of Chiropractic and Physiotherapy practice, that I have an elevated risk of contracting the virus simply by being in the practice. _____ **(Initial)**

2.2 I confirm that I am not presenting ANY of the following symptoms of COVID-19 listed below:
Fever / Shortness of Breath / Runny Nose / Sore Throat / loss of taste or smell

2.3 I am aware of the risks involved with the spread of COVID-19 and the risks it may hold to my health and the health of others I come in contact with. I accept those risks and hereby indemnify and hold the practitioner and his/her staff blameless should I contract the disease at the offices of the practitioner or from the practitioner or his/her staff members.

2.4 I accept the practice Covid-19 protocols and agree to wear a mask during my consultation.

I have read, or it has been read to me, and I understand the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to such prescribed procedures. I intend this consent form to cover the entire course of care for my present condition(s) for which I may seek care in this practice.

_____ _____

Patient's Signature (Parent/Guardian) **DATE**