NATASHA DELEY
BIOKINETICIST
PR NO: 0315591 | BK 0010456

ALICE LANE VIRGIN ACTIVE COLLECTION
34 FREDMAN DRIVE
SANDTON
2196

POSTNET SUITE 60
PRIVATE BAG X9976
SANDTON
2196

1 CONSENT TO BIOKINETIC TREATMENT BY NATASHA DELEY BIOKINETICISTS.

(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 NATASHA DELEY BIOKINETICISTS 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

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2 CONSENT TO THE RELEASE OF INFORMATION BY NATASHA DELEY BIOKINETICISTS

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

I, _____, the undersigned, do hereby give consent to **NATASHA DELEY BIOKINETICISTS** to disclose information regarding my diagnosis, 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 tick the boxes that you do give consent to:**

	YES	NO		YES	NO
Medical Scheme /Funder:	☐	☐	Lawyer:	☐	☐
Referring Doctor:	☐	☐	Employer:	☐	☐
School / Coach:	☐	☐	Parents:	☐	☐
Spouse:	☐	☐	Children:	☐	☐
Insurance Company:	☐	☐	Other Medical Practitioners	☐	☐

Other: _____

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.

I indemnify **NATASHA DELEY BIOKINETICISTS** 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.

NATASHA DELEY

BIOKINETICIST

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3. CONSENT TO FINANCIAL RESPONSIBILITY OF NATASHA DELEY BIOKINETICISTS

- I, _____, the undersigned, hereby accept full financial responsibility for this account until it is settled in full.
- Cost of treatment will be R620 for the initial consultation and R500 per session thereafter.
- 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 on or by the 25th of every month, 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.
- If still not settled within 14 days after the final warning date, the account will be handed over for legal action.

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