Dr. V. Vaghmaria (MT. Chiro., DUT)
Registered Chiropractor
(Pr. No. 004/ 000/ 0210013)

Sports Performance and Rehabilitation Centre (SPARC)
Level 2 – The Square
Cape Quarter Lifestyle Village
27 Somerset Road
Green Point

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Website: www.capechiropractic.co.za

Informed Consent

Patient Details

Title: _____ Surname: _____ First Name: _____

Date of Birth: _____ I.D. No.: _____

Gender: F M Marital Status: Single Married

Physical Address: _____ Postal Address: _____

_____ _____

_____Code: _____ _____Code: _____

Telephone: (H): _____ (W): _____ Cell: _____

Email: _____

Next of Kin: _____ Relationship: _____

Telephone: (H): _____ Cell: _____

Medical Aid Details

Medical Aid Scheme: _____ Medical Aid No.: _____

Employment Details

Occupation: _____

Company Name: _____ Telephone: _____

Physical Address: _____

_____ Code: _____

How did you hear about us?

Doctor referral _____ Family_____ Friend_____
Other _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT AND GENERAL INDEMNITY

I, _____, the undersigned, hereby request and consent to the performance of chiropractic treatment (or on the patient named below, for whom I am legally responsible) by the chiropractor and/or anyone registered as a chiropractor working in this office authorized by same. I further understand that such chiropractic services may be performed by the chiropractor and/or registered practitioner of chiropractic who may treat me now or in the future at this office

I am further aware and consent that in order to proceed with an effective treatment, my health status must be evaluated by means of an interview and/or the performance of clinical tests. The reason for this is to diagnose my condition but also to determine any contraindication I may have to any recommended treatment. I am further aware of my right to have a person of my choosing present during certain physical examinations and my right not to remain disrobed any longer than is required for accomplishing the examination.

I understand that, as with any health procedure, there are certain risks that may arise during chiropractic treatment. The risks associated with joint manipulation and mobilization are typically minor if they occur, possible side effects include mild to moderate discomfort, autonomic phenomena such as dizziness, headaches and post treatment discomfort. More severe complications are extremely rare but have been reported, such as fractures, dislocations, disc herniation or progression of neurological symptoms and stroke. Other chiropractic treatments that this practice may utilize are dry needling therapy, electrotherapy, temperature therapy, soft tissue therapy, strapping and bracing. Risks associated with these therapies include bleeding, bruising, infection, lung puncture, pain, autonomic phenomenon such as dizziness and nausea, burns, electrocution, skin irritation and discomfort.

Should I experience any side effects, I confirm that I will immediately notify my chiropractor and inform him of same. My failure to raise any concern will create the assumption that I am satisfied with the service provided and further indicates that I am not experiencing any side effects to the treatment provided.

I acknowledge that I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, the treatment options and recommendations for my condition, costs and the contents of this consent. I also understand that results are not guaranteed.

I intend for this consent to apply to my present treatments and, in future, should it occur that my condition changes during the course of my treatment, I will participate in any decision affecting my personal health and course of treatment. I further note my right to withdraw my consent at any time for any specific procedure and/or treatment.

I understand my chiropractor's legal duty and herewith consent to the disclosure of my diagnosis to the medical schemes, other medical professionals and support staff in the employ of this practice for purposes of reimbursement and/or settlement of my account, administrative tasks and/or referral. I also hereby accept full financial responsibility for this account until it is settled in full. I confirm that all details provided are both true and correct. It has further been explained to me the costs involved in chiropractic treatment and agree to said costs. I also understand that should I not cancel an appointment within twenty four (24) hours of said appointment I may be invoiced for the full amount.

I further understand that access to the premises of the chiropractor and the use of all facilities is done at my own risk. Neither the owner of the premises nor the chiropractor who operates the business or their employees, agents or anyone temporarily in their service shall be liable for any damage, loss and/or injuries sustained as a result of such entry unto the premises and I hereby indemnify the owner of the premises, the chiropractor/s and all employees in their service, agents and/or temporary workers against any liability for loss or damage of any kind whatsoever.

INFORMED CONSENT REGARDING PERSONAL AND MEDICAL INFORMATION

I, _____, the undersigned, understand my chiropractor's legal duty and herewith consent to the disclosure of my diagnosis (ICD-10 codes) to the medical schemes for purposes of reimbursement and/or settlement of my account. I further understand that this disclosure has consequences and same has been explained to me.

I acknowledge that once my information has been sent to the relevant medical scheme, Dr V Vaghmaria - Chiropractor has no further control over the management and utilisation of the information and understand that the medical scheme will take responsibility for any further disclosure or utilization of such information for whatever purpose.

I further understand and consent to the disclosure of my medical information to other chiropractors and support staff in the employ of Dr V Vaghmaria - Chiropractor. It has been explained to me that each member of the staff has signed a confidentiality agreement which ensures that they are not able to disclose my personal and medical information to any third party, family member etc. of the respective employee.

Dr V Vaghmaria - Chiropractor will not disclose any personal and medical information to any of my friends or family members unless express consent is given by me, authorising them to disclose certain information to same.

I have the right to withhold my consent to the disclosure of my personal and medical information and understand that same will result in me having to reimburse and settle the account directly with Dr V Vaghmaria - Chiropractor.

I intend for this consent to apply to my present treatment and, in future, should it occur that my condition changes during the course of my treatment, I will sign a new informed consent form to give effect to said decision.

I indemnify Dr V Vaghmaria - Chiropractor 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 harmless of any further disclosures and prejudice I may suffer as a result of such disclosures.

_____	_____	_____
Patient's Signature (Parent/Guardian)	Person Responsible for the Account	DATE

_____	_____
Witness Signature	DATE

INFORMED CONSENT TO THE FINANCIAL RESPONSIBILITY OF MY ACCOUNT

I, _____, the undersigned, hereby accept full financial responsibility for this account until it is settled in full. I confirm that all details provided are both true and correct. It has further been explained to me the costs involved in chiropractic treatment and agree to said costs.

I understand that should I not cancel an appointment within twenty four (24) hours of said appointment I will be invoiced for the full amount.

I accept that Dr V Vaghmaria - Chiropractor is not contracted to any Medical Aids. All payments will be made directly to the Chiropractor on presentation of the account.

Should I not effect payment of any outstanding invoice, Dr V Vaghmaria - Chiropractor will proceed as follows:

1. A follow up telephone call, sms or e-mail will be sent should the account not be paid within thirty (30) days;
2. A final written warning will be sent via e-mail to my personal e-mail address should the account not be paid within sixty (60) days;
3. Should I not settle the invoice after receipt of the final written warning, the account will be handed over to attorneys for further legal action;
4. I acknowledge that as a result of my failure to pay the account, I will be liable for all legal fees, on an attorney client scale, incurred in the collection of the outstanding account.

I herewith confirm the aforementioned and further that all cost implications have been communicated to me.

_____ _____

Patient's Signature DATE

(Parent/Guardian of patient should the patient be younger than eighteen)

_____ _____

Witness Signature DATE