PATIENT FORM

BIO4U BIOKINETICISTS 0359955

PATIENT INFORMATION

Title | Initials | Gender | Age | Occupation

Name | Surname

ID Nr. | Cell Phone Nr.

Email Address | Alt. Contact Nr.

PERSON RESPONSIBLE FOR ACCOUNT – *Complete if this is different from Patient*

Title | Initials | Gender | Age | Occupation

Name | Surname

ID Nr. | Cell Phone Nr.

Email Address | Alt. Contact Nr.

Physical Address | Code

MEDICAL AID DETAILS

Medical Aid Name | Medical Aid Nr.

Main Member Name(s) & Surname | Cell Phone Nr.

ID Nr. | Email Address

DISCOVERY MEDICAL AID MEMBERS

Would you prefer if we claim directly from Discovery? (fees come from savings) ☐ Yes * ☐ No

* You remain responsible for your account if Discovery does not pay for any if the appointments for any reason

ALL MEDICAL AID MEMBERS THAT ARE PAYING THE PRACTICE DIRECTLY (EFT / CASH)

Do you want a receipt to claim back from your medical aid? (fees come from savings) ☐ Yes ☐ No

IN CASE OF EMERGENCY

Name & Surname | Cell Phone Nr. | Relation to Patient

OFFICE USE

Biokineticist | Date

INFORMED CONSENT

MUST BE SIGNED BY ALL PATIENTS OLDER THAN 12 YEARS

A. CONSENT TO ASSESSMENT & TREATMENT

As part of your consultation you will need to undergo some form of physical assessment. This assessment is essential to determine the nature/cause of your injury and/or to determine your level of fitness, strength, flexibility, balance, endurance, etc.

As part of your treatment you will need to undergo some form of physical exercise. This exercise is essential to address the nature/cause of your injury and/or to improve your level of fitness, strength, flexibility, balance, endurance, etc.

1. I am aware that during the consultation and follow-up consultations I might need to uncover specific body parts, and I understand that I may refuse to do so if and when I feel uncomfortable.
2. I am aware that the Biokineticist may need to touch me in order to: a. perform a number of assessments; b. provide tactile cues in order to provide effective treatment, and that I will inform the Biokineticist if and when I feel uncomfortable.
3. I am aware that it is my right to withdraw this consent at any time or for any specific assessment, or for any specific treatment or intervention.
4. I am aware that during the assessment and treatment I will be required to do physical exercise. I am also aware that exercise may naturally cause muscle stiffness and soreness. It remains my responsibility to inform the Biokineticist of any discomfort and/or aggravation of symptoms.
5. I have been informed about the need for the assessment and of the potential benefits and risks/complications of doing the assessment as well as the treatment / intervention.
6. I have been informed of alternative assessments, treatment options or interventions.
7. I am aware that I may stop the assessment and the treatment/intervention at any time to discuss any concerns.
8. I have disclosed all my medical conditions, medications, and any other related information and understand that all information will be treated with the utmost confidentiality.
9. I hereby consent to the assessment and treatment / interventions that will be performed on me / my dependent: subject to the Biokineticist performing the relevant tests and evaluations along with taking relevant safety precautions.
10. I agree that additional Biokineticist / Biokinetics-students may shadow the Biokineticist for educational purposes.
11. In case of emergency: I furthermore grant the Practice and / or a contractor, and / or support staff permission to arrange for the necessary medical assistance that may be required in case of injury or emergency, should I be unable to do so myself. I am aware that it is my responsibility to provide written evidence of any Do Not Resuscitate (DNR) arrangements, and that these may be ignored by emergency personnel according to South African legislation.

B. CONSENT TO FINANCIAL RESPONSIBILITY

It is important to note that there is a cost involved with the Biokinetics services offered by the Practice, and patients are under financial obligation to pay. The initial consultation and follow-up appointments vary in cost depending on the service required.

1. I am aware that there is a cost involved (fee for service), the cost is my responsibility and I am under financial obligation to pay.
2. I hereby declare all personal and financial information as true and correct and I understand that all information will be treated with the utmost confidentiality.
3. Appointments not cancelled 6 hours before the time of appointment will be charged (which cannot be claimed from a medical aid). I am personally responsible to ensure that I am attentive of all appointment dates and times. Appointments not kept due to date and time errors, will be charged for. If uncertain about appointments, please phone the practice to confirm.
4. This is a cash practice and you are kindly requested to settle your account by cash or EFT upon receiving the invoice, unless otherwise arranged. A receipt with the necessary codes will then be issued for reimbursement from your medical aid.
5. Accounts will be rendered electronically. Please check all information and notify us as soon as possible of any changes or discrepancies.
6. I am aware that the Practice is contracted out of medical aid.
7. The consultation is a business transaction between the patient and the Biokineticist. Medical aid companies constitute a third party that is not directly involved in the provision of the Biokinetics service. It is therefore my responsibility to deal with the medical aid, submit claims, and deal with queries.
8. It is my responsibility to clarify and rectify any mistakes made by the medical aid with the medical aid.
9. I understand that this practice's private fees are charged in accordance to medical aid rates.
10. 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.
11. I understand that I will be responsible for all legal fees involved, if legal action is needed to collect any outstanding fees.
12. 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.

C. CONSENT TO MANAGEMENT OF INFORMATION

As part of your consultation and ongoing treatment your information will need to be captured, stored and possibly shared. Ethically and legally appropriate capturing, sharing and storing of information is essential in terms of the National Health Act (NHA), the Health Professions Act (HPA) (and the Professions Council of South Africa (HPCSA) guidelines), the Public Access to Information Act (PAIA), and the Protection of

Personal Information Act (POPIA). The capturing, storing and sharing of information needs to be compliant with the abovementioned legislation and you need to consent to the capturing, storing and sharing of your personal information, your medical results, your medical history, information necessary for financial statements / medical aid claims:

1. I do hereby give consent to the Practice to disclose information regarding my diagnosis (ICD 10 Coding), 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 options you give consent to):

☐ Medical Scheme/Funder	☐ Employer
☐ Medical Professional	☐ School/Coach
☐ Parents/Children	☐ Lawyer
☐ Spouse/Partner	☐ Insurance Company

2. 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.
3. I indemnify the Practice 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 consultants blameless of any further disclosures and or prejudice I may suffer as a result of such disclosures.

D. CONSENT TO DIGITAL COMMUNICATION

As part of your consultation and ongoing treatment it may be required to communicate using digital / electronic / distance / non-face-to-face / telemedicine platforms as a method of communication. It is important to acknowledge that face-to-face care is the best form of care, however it is not always practical or possible.

Patient-biokineticist communication via digital / electronic / distance / non-face-to-face / telemedicine needs to be compliant with the NHA, the HPA (and the HPCSA guidelines), the PAIA, and the POPIA. Ethically and legally appropriate capturing, sharing and storing of information still applies to patient- biokineticist communication via digital / electronic / distance / non-face-to-face / telemedicine platforms. Your patient information will need to be captured, stored and possibly shared using a third-party. The PAIA and POPIA require that these third-party platforms are located in countries that have similar or better privacy legislation than South Africa.

The capturing, storing and sharing of information needs to be compliant with the above mentioned legislation and you need to consent to the use of third-party platforms involved in the digital / electronic / distance / non-face-to-face / telemedicine correspondence. These third-party platforms may play an indirect role in the capturing, storing and sharing of your personal information, your medical results, your medical history, information necessary for financial statements / medical aid claims.

1. I fully understand that this is a legal requirement and that I have a choice not to consent to such information being disclosed to / via any third-party.
2. I indemnify the Practice 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 associates blameless of any further disclosures and or prejudice I may suffer as a result of such disclosures.

E. CONSENT TO TREATMENT & ASSUMPTION OF COVID-19 RISK

1. I have been given the option to defer my treatment to a later date or via an online telehealth consultation. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment despite the risk.
2. I understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result the South African Government and international health agencies recommend social distancing.
3. I understand that, even if I have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment can lead to a higher chance of complication and in extreme circumstances death.
4. I understand that possible exposure to COVID-19 before/during/after my treatment may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, and possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.
5. I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.
6. I recognize that the Practice has been closely monitoring this situation and has put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment.
7. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and I give my express permission for the Practice to conduct treatment at my request.

I confirm that I have exercised my choice voluntarily and that this declaration was not made under duress.

Digitally sign the informed consent with your Name, ID and tick the acceptance block.

☐ ***I have read and accept the Biokinetics Informed Consent which can be downloaded here.***

Name & Surname	
ID Nr.	
Signature	☐ _____
Date	

A. MEDICAL HISTORY / RISK SCREENING

Please click at the relevant box(es) - if you have ever had any of the below mentioned conditions:

1. HEART CONDITIONS - Have you ever had:

- ☐ A heart attack
- ☐ Heart surgery
- ☐ Coronary angioplasty
- ☐ Pacemaker/implantable defibrillator/rhythm disturbance
- ☐ Congenital heart disease
- ☐ Heart failure
- ☐ Heart transplantation
- ☐ Cardiac catheterisation
- ☐ Heart valve problem
- ☐ You take heart medication(s) *(list meds & dosage)*

2. CURRENT SYMPTOMS - You experience signs & symptoms like:

- ☐ Chest discomfort/pain with exertion (Angina)
- ☐ Dizziness, fainting / blackouts
- ☐ Unpleasant awareness of a forceful / rapid heart rate
- ☐ Ankle swelling
- ☐ Unusual fatigue / shortness of breath with light activities
- ☐ Unreasonable breathlessness
- ☐ Burning / cramping in your lower legs when walking a short distance
- ☐ Sleep Apnoea (snore yourself awake)

3. PRECLUSIONS - Please indicate if any of the below mentioned is relevant to you:

- ☐ Male - older than 45 years
- ☐ Female - older than 55 years
- ☐ Smoker / quit smoking within the previous 6 months
- ☐ Diagnosed high blood pressure (≥ 140/90 mmHg)
- ☐ You take blood pressure medication *(list meds & dosage)*
- ☐ Diagnosed high cholesterol (> 5.2 mmol/l)
- ☐ You take cholesterol medication *(list meds & dosage)*
- ☐ Diagnosed Diabetes *Type 1 / 2*
- ☐ You take diabetes medication *(list meds & dosage)*
- ☐ You have pre-diabetes
- ☐ You are physically inactive (i.e. you exercise less than 150 minutes per week)
- ☐ You have a Body Mass Index ≥ 30kg/m^2
- ☐ Blood clotting problems *(list meds & dosage)*

4. ADDITIONAL - Do you have any of the following:

- ☐ Asthma / other lung problems
- ☐ Osteoporosis / Osteopenia (diagnosed low bone density)
- ☐ Other prescription medication *(list meds & dosage)*
- ☐ You are pregnant ____ *weeks*
- ☐ Post-Natal ____ *weeks*
- ☐ Complications with pregnancy? *(indicate complications)*

Please bring a list of all your medications if it does not fit in the above blocks.

- ☐ Any muscle / joint problems that limit / could be aggravated by physical activity
- ☐ Allergies *(list allergies)*

5. Any other medical conditions:

6. Close blood relative medical history: Please indicate if any of the below mentioned is relevant:

☐ Male Family History: <age 55 (father/brother)

- ☐ Heart Disease
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Heart Attack *Cancer Type*

☐ Female Family History: <age 65 (mother/sister)

- ☐ Heart Disease
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Heart Attack *Cancer Type*

Tell us more about yourself and why you need our help

B. INJURY / PAIN / HISTORY

1. Where is your primary injury / pain / problem / complaint? **With what are we helping immediately?**

☐ Shoulder ☐ right ☐ left ☐ Knee ☐ right ☐ left ☐ Upper Back (area between shoulder blades)

☐ Hip ☐ right ☐ left ☐ Ankle ☐ right ☐ left ☐ Lower Back ☐ Neck

☐ Groin ☐ right ☐ left ☐ Other *(specify below)* ☐ Muscle *(specify below)*

2. How did the injury happen?

☐ Accident ☐ Fall ☐ Suddenly ☐ Over Time ☐ Spontaneous / No Specific Cause

☐ After Surgery *when was the surgery?*

Did it happen while ☐ Walking ☐ Jogging ☐ Running ☐ Other

Explain in short:

3. When did it happen? / Since when do you have this problem?

4. Was there a ☐ click or a ☐ "pop" when the injury occurred? ☐ Not with this injury

5. How would you describe your pain?

☐ Cramping ☐ Sharp, Shooting ☐ Dull ☐ On a specific spot ☐ More alongside your spine

☐ Pressure ☐ Burning ☐ Nagging ☐ No specific spot ☐ Centre of your spine

☐ Stinging ☐ Deep ☐ Aching ☐ Other *(explain in the block below as best as you can)*

☐ Radiating *where does it radiate to?*

The pain is - ☐ Better ☐ Worse ☐ Same - since injury

The pain is - ☐ Better ☐ Worse ☐ Same - with activities

6. What is your Pain Intensity now (at this moment)? *0 = No Pain ; 10 = Unbearable* ☐ /10

7. What is your Pain Intensity when you do have symptoms? *0 = No Pain ; 10 = Unbearable* ☐ /10

8. When do you experience the pain / symptoms?

☐ During activities / sport ☐ Intermittent / Sometimes ☐ At night

☐ After activities / sport ☐ All the time ☐ Pain gets worse when couching / sneezing

9. Swelling: ☐ Never ☐ Always ☐ During activities ☐ After activities

10. Do you ever experience any of the following?

☐ Grinding ☐ Clicking ☐ Joint giving away ☐ Locking of joint ☐ Back (spine) feels unstable

11. What makes your symptoms / pain worse (select at the body region that we have to help with, e.g. knee or shoulder or back)**?**

Neck
- ☐ Tilt head up
- ☐ Tilt head down
- ☐ Rotate head to right
- ☐ Rotate head to left
- ☐ Tilt head to right shoulder
- ☐ Tilt head to light shoulder

Back
- ☐ Forward bend
- ☐ Coming back up from forward bend
- ☐ Backward bend
- ☐ Side bend to right
- ☐ Side bend to left
- ☐ Rotate to right
- ☐ Rotate to left
- ☐ Lying on your back
- ☐ Lying on your stomach
- ☐ Lying on your right side
- ☐ Lying on your left side
- ☐ Prolonged sitting
- ☐ Prolonged standing
- ☐ Prolonged walking
- ☐ Prolonged jog-/running

Shoulder
- ☐ Lifting arm forward
- ☐ Taking arm backward
- ☐ Lifting arm away from your side
- ☐ Rotating arm inwards
- ☐ Rotating arm outwards
- ☐ Hugging yourself
- ☐ Reaching to your low back

Hip
- ☐ Lifting leg forward
- ☐ Taking leg backward
- ☐ Lifting leg to the side (legs apart)
- ☐ Crossing your legs
- ☐ Rotating leg inward
- ☐ Rotating leg outward
- ☐ Prolonged sitting
- ☐ Prolonged standing
- ☐ Prolonged walking
- ☐ Prolonged jog-/running

Knee
- ☐ Bending
- ☐ Straighten
- ☐ Stairs up
- ☐ Stairs down
- ☐ Prolonged sitting
- ☐ Prolonged standing
- ☐ Prolonged walking
- ☐ Prolonged jog-/running

Ankle
- ☐ Pointing
- ☐ Lifting foot upward
- ☐ Tilting inwards
- ☐ Tilting outwards
- ☐ Stairs up
- ☐ Stairs down
- ☐ Prolonged sitting
- ☐ Prolonged standing
- ☐ Prolonged walking
- ☐ Prolonged jog-/running

☐ Other

12. What makes your symptoms / pain better?

13. Do you struggle putting on your shoes? ☐ Yes ☐ No

14. Can you go down to the floor with ease, and get up again? ☐ Yes ☐ No

15. Can you stand on your knees (kneeling on hands & knees)? ☐ Yes ☐ No

16. Do you have other injuries / pains that we should be aware of?

17. What treatment (e.g. physio / chiro / etc.) have you received for your current injury? Or previous injuries?

18. Do you have exercise equipment at home?

Name some of your equipment at home

19. Are you a gym member? ☐ Yes ☐ No