VITALITY CLIENT FORM

BIO4U BIOKINETICISTS 0359955

CLIENT INFORMATION

Title | Initials | Gender | Age | Occupation

Name | Surname | ID Nr.

Cell Phone Nr. | Email Address

MEDICAL AID DETAILS

Main Member Name(s) & Surname | Medical Aid Name | Medical Aid Nr.

ID Nr. | Cell Phone Nr. | Email Address

DISCOVERY MEDICAL AID MEMBERS

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

IN CASE OF EMERGENCY

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

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. CURRENT HEALTH CONDITIONS - Do you have any of the following:

- ☐ Asthma / other lung problems
- ☐ Kidney disease
- ☐ Any muscle or joint problems that limit your physical activity or that could be aggravated by physical activity
- ☐ Have concerns about the safety of your exercise
- ☐ You are pregnant ____ *weeks*

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

- ☐ Male - older than 45 years
- ☐ Diagnosed Diabetes *Type 1 / 2* ____
- ☐ Female - older than 55 years
- ☐ You take diabetes medication *(list meds & dosage)*
- ☐ Smoker / quit smoking within the previous 6 months
- ☐ Diagnosed high blood pressure (≥ 140/90 mmHg)
- ☐ You have pre-diabetes
- ☐ You take blood pressure medication *(list meds & dosage)*
- ☐ You are physically inactive (i.e. you exercise less than 150 minutes per week)
- ☐ Diagnosed high cholesterol (> 5.2 mmol/l)
- ☐ You have a Body Mass Index ≥ 30kg/m^2
- ☐ You take cholesterol medication *(list meds & dosage)*
- ☐ You have a close blood relative who had a heart attack before age 55 (father or brother) / age 65 (mother or sister)

INFORMED CONSENT

A. CONSENT TO ASSESSMENT

1. I do hereby consent to health screening as part of the Vitality Fitness Assessment/ Vitality Functional Assessment.
2. I acknowledge that this is a screening assessment and should any of my tests fall outside of normal parameters, I am responsible for monitoring further investigations that can be required.
3. If one or more of the 'Medical History' or 'Preclusions' checkboxes are checked, I understand that I should consult with a doctor and get clearance before doing a fitness test. If I do come for the assessment without a clearance letter, I take full responsibility for anything that may happen.
4. I agree that Discovery Vitality and its contracted research partners may use the results from the Vitality Fitness Assessment/ Vitality Functional Assessment for statistical and research purposes. Data will be anonymised.
5. My participation in the Vitality Fitness Assessment/ Vitality Functional Assessment, is voluntary and at my own risk. I am aware that under no circumstances, including as a result of its negligent acts or omissions or those of its staff, servicers, agents, contractors, partners or other persons for whom in law it may be liable, will Vitality or the Biokineticist conducting this assessment be liable for any loss, injury or damage of any nature which I, my beneficiaries or any third parties may sustain as a result of my participation in this Vitality Fitness Assessment/ Vitality Functional Assessment/ Vitality High Performance Fitness Assessment. I further confirm that the information provided by me in this consent form is true and correct and shall not hold Discovery Vitality/ Discovery Limited and/or the Biokineticist for any misrepresentation of such information.
6. *I understand that the assessment is not suitable for pregnant women and that Discovery Vitality will not be liable for any injury to myself or my unborn child should I request the bio to perform the assessment while I am pregnant. Should there be a need for Discovery Vitality to process your personal information arising from the Vitality Fitness Assessment/ Vitality Functional Assessment/ Vitality High Performance Assessment, Discovery Vitality confirms that such processing shall be in line with the Vitality Main Rules.
7. I am aware that the Biokineticist may need to touch me in order to: a. perform a number of assessments; b. provide tactile cues if needed, and that I will inform the Biokineticist if and when I feel uncomfortable.
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 agree that additional Biokineticist / Biokinetics-students may shadow the Biokineticist for educational purposes.
10. 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

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. 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.
4. Accounts will be rendered electronically. Please check all information and notify us as soon as possible of any changes or discrepancies.
5. I am aware that the Practice is contracted out of medical aid.
6. The assessment is a business transaction between me 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.
7. It is my responsibility to clarify and rectify any mistakes made by the medical aid with the medical aid.
8. 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.
9. I understand that I will be responsible for all legal fees involved, if legal action is needed to collect any outstanding fees.

C. CONSENT TO MANAGEMENT OF INFORMATION

As part of your assessment, your information will need to be captured, stored and shared. You need to consent to the capturing, storing and sharing of personal information, your results, your medical history, and information necessary for financial statements / medical aid claims. I do hereby give consent to the Practice to disclose information regarding my assessment 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 ☐ Insurance Company
☐ Medical Professional ☐ Spouse/Partner

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 ASSESSMENT & ASSUMPTION OF COVID-19 RISK

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 assessment despite the risk. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this assessment and I give my express permission for the Practice to conduct the assessment at my request. Please have a look at the full COVID-19 RISK consent, which you can download ***here***.

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	