Dr Kate Brown T/A Kate Brown Chiropractic

INFORMED CONSENT TO CHIROPRACTIC TREATMENT & 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.

Any video recordings or photography of treatments/manipulations are prohibited unless expressly permitted by the Chiropractor and for private use only. Such recordings and videography may under no circumstances be shared or distributed in any way or form on any public platform, be it social media or WhatsApp group or any other public domain or area where more than one person will have access to such video or photograph. Any such actions will be in contravention of the rules of the AHPCSA and will breach practitioner and patient confidentiality.

_____ _____

Patient's Signature (or Parent/Guardian) DATE

_____ _____

Person Responsible for the Account DATE

_____ _____

Witness Signature DATE

POPIA AND INFORMED CONSENT TO THE RELEASE OF PERSONAL AND MEDICAL INFORMATION

In keeping with the regulations according to the Protection of Personal Information Act (POPI) 4 of 2013, all information handled by the practice is regarded and treated as strictly confidential by the healthcare professional and practice staff. Legislation requires the practice to provide certain information on accounts, including diagnostic information. Failure to submit the correct codes may lead to claims being rejected or incorrectly paid by your medical aid scheme. The practice must also provide ICD-10 codes on referral letters, requests for special investigations such as radiology, pathology, etc.

In the event of a third-party request for confidential information from the practice, and in doubt regarding the safety of confidentiality processes, the practice may insist on following the standard operating procedures legislated in any legislation.

I, _____, the undersigned, hereby consent in terms of the Protection of Personal Information Act 4 of 2013 ("POPIA") as amended from time to time, that the practice may share my personal information (including diagnostic information) for practice administration services, including external practice administration providers contracted by the practice, historical, statistical, research purposes, or practice business planning with other service providers to enhance systems and services, this to include sharing the personal information with other healthcare practitioners, medical schemes, and their relevant administrators, claim/invoice switch houses in the course of providing the services to myself.

I understand and acknowledge that my personal information will be securely retained by the practice after my last visit to the practice, for as long as is required by legislation.

I understand and acknowledge that the practice will not transfer or authorise the transfer of personal information to countries outside of the Republic of South Africa without my prior written consent. If personal information processed under section 72(1)(b) of POPIA is transferred from the Republic of South Africa to a third party in another country, the transferring party shall comply with sections 72, 57 and 58 of POPIA.

I further hereby consent that the practice may contact me by any of the communication methods/platforms, namely: phone, email, SMS, Whatsapp or similar services. I understand that these platforms will be used for professional communication only. This will include (but not be limited to) accounts, statements and information, practice information, system updates, professional updates, and reports where necessary and indicated. I acknowledge that none of these communications are completely secure or encrypted communications, and I will not hold the practice liable for any breach of confidentiality via these communications.

I 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, the practice 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 the practice. The practice 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 Kate Brown. 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 the practice and Dr Kate Brown 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 DATE

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

_____ _____

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.

Accounts will be rendered electronically and it is my duty to ensure that all information is correct. Should information be incorrect I will ensure that I notify Dr Kate Brown within a reasonable time. I further am responsible to rectify/clarify and mistakes/errors made by the medical aid with the medical aid directly, Dr Kate Brown will not be liable/responsible for said mistakes/errors.

In the event of an injury on duty, it is my responsibility to submit the necessary documentation within ten (10) days after the starting date of the treatment. Should I fail to submit same, I will become liable for the full amount.

Should I not effect payment of any outstanding invoice, Dr Kate Brown will proceed as follows:
A follow up telephone call, sms or e-mail will be sent should the account not be paid within thirty (30) days;
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;
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;
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 costs implications have been discussed with me.

_____ _____

Patient's Signature DATE

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

_____ _____

Witness Signature DATE

WITHDRAWAL OF CONSENT

I understand that it is my right to withdraw consent or refuse care at any time or for any specific procedure. I further confirm that in doing so there are, or might be, implications, risks and obligations for my health. The chiropractor has explained such implications, risks and obligations to me.

I have considered these implications, risks and obligations, and herewith confirm my withdrawal of consent for the following procedure or evaluation:

_____

_____

_____

_____ _____

Patient's Signature DATE

(Parent/Guardian should the patient be a minor)

_____ _____

Witness Signature DATE

ANNEXURE "A" Information forms

MANIPULATION, MOBILIZATION AND TRACTION

Procedure

This procedure involves the movement of joints within their physiological range of motion. It is often associated with an audible popping sound.

Risks

The risks associated with these procedures 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. The reported risk of severe complications range from 1 in 1 hundred thousand to 1 in 2 million. This sounds concerning but to put this in perspective your chances of getting serious side effects or even death due to NSAID's use is over 100 in 1 million. Be aware that all preventative measures and techniques will be used to limit risks associated to this procedure as well as screening for any signs, symptoms or conditions that may increase your risk as an individual (such as osteoporosis would increase the risk of fracture and therefore softer manipulative techniques would be used).

Please note that you should report any side effect to your chiropractor immediately so that interventions can be done if necessary. In particular please be alerted to any nausea, vomiting, loss of balance, headaches, changes in sensation to any part of the body, loss of muscular power and slurred speech.

DRY NEEDLING THERAPY

Procedure

This procedure involves the insertion of a needle into myofascial trigger points (“knots” in muscle or fascia).

Risks

It is a safe procedure in most areas of the body but may result in bleeding, bruising, infection, localized as well as referred pain and autonomic phenomena such as dizziness and nausea. There is an increased risk when performing this procedure over the lung fields as it is possible for the needle to cause a pneumothorax (air trapped in the thoracic space that can prevent normal inflation of the lung). Symptoms of a pneumothorax include chest pain and shortness of breath.

Please notify your chiropractor immediately should this occur at any point after this procedure. All preventative measures and techniques will be used to limit risks associated to this procedure.

ELECTROTHERAPY

Procedure

This involves the use of electrical current to aid in the treatment of varying conditions. Devices that could be used in electrotherapy include, but are not limited to, interferential current and transcutaneous nerve stimulation.

Risks

There is risk of burns, electrocution, skin infection from the electrode covers and some discomfort.

Please notify your chiropractor immediately should any side effects occur.

TEMPERATURE THERAPY

Procedure

This involves the use of heat or cold to aid in the treatment of varying conditions. Cold or heat packs could be used and in some cases devices such as ultrasound and laser.

Risks

There is a risk of burns and mild discomfort.

Please notify your chiropractor immediately should any side effects occur.

SOFT TISSUE THERAPY

Procedure

This involves the manipulation of soft tissue utilizing the hands or in some cases varying devices or instruments. These devices include, but are not limited to, Faktr, Thumper and Shock Wave.

Risks

There is a risk of bruising, fracture, skin irritation and discomfort.

Please notify your chiropractor immediately should any side effects occur.

STRAPPING AND BRACING

Procedure

This involves the use of strapping and/or bracing to aid in the treatment of varying conditions.

Risks

There is a risk of skin irritation, infection and discomfort.

Please notify your chiropractor immediately should any side effects occur.