DEBBIE COHEN
PHYSIOTHERAPY

Bsc PHYSIO (Wits)
Registered Physiotherapist
PR 7226934

PHYSIOTHERAPY CONSENT FORM

IT IS ROUTINE PROCEDURE FOR YOUR DOCTOR TO PRESCRIBE PRE / POST OPERATIVE PHYSIOTHERAPY.
THIS WILL CONSIST OF VISITS BY THE PHYSIOTHERAPIST, DEBBIE COHEN / ONE OF MY LOCUMS, IN THE HOSPITAL.

The physiotherapy consists of the following:

- CHEST PHYSIOTHERAPHY (BREATHING EXERCISES). TO PREVENT LUNG COMPLICATION / PNEUMONIA
- CIRCULATORY EXERCISES TO PREVENT THROMBOSIS
- BED MOBILITY
- WALKING (IF NECESSARY)
- SUCTIONING / SPUTUM SAMPLE (IF ORDERED)
- NECK / BACK TREATMENT (IF APPLICABLE)

Contract

I confirm that I have been informed of the purpose of Physiotherapy and I confirm that the risks and complication generally associated with Physiotherapy have been explained to me. I understand the option offered to me and have made my choice.

I agree to allow my personal data to be forwarded to the relevant organisations as required by law and to allow anonymous data of a clinical and practice management nature, to be collected to help improve the patient healthcare experience.

The account is rendered completely separate from other medical accounts. The fee is based on the South Africa Society of Physiotherapy guidelines (NRPL rates) I agree to pay the NRPL fee. I understand that I might not be fully reimbursed by my medical aid.

I understand that I am personally responsible for payment of the account and that I am responsible for claiming my refund from my medical aid. The fee is due and payable immediately on completion of the service. The account is rendered directly to you as required by the Medical schemes act No: 131 of 1998.

I agree to pay the Physiotherapist fee. I understand that I may be offered a discount for early settlement, i.e. 30 days from date of service. I understand that I remain personally responsible for payment of the account as per this agreement. I understand that I have a separate agreement with my medical aid which may not fully reimburse me. Upon payment a receipt will be issued on request to enable me to claim a refund from my medical fund.

I understand that all appointments not cancelled within 24 hours will be charged for my account. There can be no unilateral changes to this agreement.

Please note that if payment is not made within 90 days, the account will be handed over to out attorneys for collections. You will be held liable to pay any collection and / or attorney fees on the Attorney client scale.

I also undertake to pay all legal costs on the attorney and own client scale as well as all tracing costs and charges as stipulated by the Debt Collections Act 114 of 1998 relating to the recovery of fees outstanding on my account in respect of professional services rendered. I consent to sharing information on my account with other credit grantors and with the credit bureaux. Information shared with these companies is used only to make credit-granting decisions and to prevent fraud.

I agree that the practitioner shall be entitled to charge me all legal costs and disbursements incurred by the practitioner in connection with the appointment of any agents and / or attorneys to recover any amount owing by me.

I consent to sharing information on my account with other credit grantors and with the credit bureau.

I hereby choose my above address as my DOMICILUM CITANDI ET EXECUTANDI for all purposes under this agreement and I agree that any notice sent to the above address by prepaid registered post will be deemed to have been received by me on the third business day after the posting of it.

I further agree that any notice received by me by any means and at any address will be valid for all legal purposes notwithstanding that it was not sent by registered post or to my DOMICILUM CITANDI ET EXECUTANDI. I agree that should I wish to change my DOMICILUM CITANDI ET EXECUTANDI I will give one week's prior written notice for such change to become effective.

I have read, understood and agree to the contents herein. I confirm that the particulars furnished by me are in all respects true and complete.

I hereby give permission for treatment to be administered to my dependant(s) and / or myself.

PATIENT'S FULL NAME:_____

SIGNATURE:_____DATE:_____

www.DebbieCohenPhysio.co.za
M 082 561 1806 T 011 485 3489 F 086 654 6652 E Admin@DebbieCohenPhysio.co.za

8 Kyrhin Street
Rouxville
JHB, 2192

Parklane Clinic
Junction Road
Parktown, 2193

Linksfield Clinic
126 17th Street
Orange Grove, 2192

PO Box 51004
Raedene
2124