THE HILLCREST

CHIRO

INITIAL ATTENDING PRACTITIONER (HEREINAFTER REFERRED TO AS THE 'CHIROPRACTOR')

☐ Dr Nicole Moulder
MTech Chiro (DUT)
Practice No. 0133205

☐ Dr Neil Cuninghame
MTech Chiro (DUT)
PG Dip Int Disc Pain Mngmnt (UCT)
Practice No. 0354740

☐ Dr Kate Jones
MTech Chiro (DUT)
Practice No. 0562580

PATIENT DETAILS

Title	Initials	Surname
Full Names		Occupation
Age	ID No.	
Email		
Cell No.		Tel No.

MEDICAL AID DETAILS

Medical Aid	
Option Plan	Medical Aid Number

PERSON RESPONSIBLE FOR ACCOUNT (HEREINAFTER REFERRED TO AS THE 'MEMBER')

Title	Initials	Surname
Full Names		
Physical Address		
ID No.		Date of Birth
Employer		
Home No.		Work No.
Cell No.		Email
Spouses Cell No.		Spouses Work No.

NEXT OF KIN (NOT AT THE SAME ADDRESS)

Full Name and Surname	
Relationship	Tel No.

REFERRED BY

Name

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MEDICAL CONDITIONS (PLEASE TICK RELEVANT BOX)

Allergies	☐	Cancer	☐	Heart Disease	☐
Anxiety or Depression	☐	Cholesterol	☐	Osteoporosis	☐
Asthma	☐	Stroke	☐	Pregnancy	☐
Blood Pressure (Low)	☐	Diabetes	☐	Thyroid Problem	☐
Blood Pressure (High)	☐	Fractures	☐	Whiplash Injury	☐

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

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. Please see Annexure “A” for more information.

Should I experience any side effects, I confirm that I will immediately notify the Chiropractor. 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 the 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 the 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.

PATIENT’S SIGNATURE (PARENT/GUARDIAN)	PERSON RESPONSIBLE FOR ACCOUNT	WITNESS SIGNATURE
DATE		DATE

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INFORMED CONSENT TO THE RELEASE OF PERSONAL AND MEDICAL INFORMATION

I, _____, the undersigned, understand the 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 Chiropractor and The Hillcrest Chiro have 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 Hillcrest Chiro. 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.

The 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 the 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 the Chiropractor from any liability or damages whatsoever that I may suffer as a result of this disclosure and I will hold the Chiropractor, The Hillcrest Chiro, and it's staff harmless in any further disclosures and prejudice that I may suffer as a result.

PATIENT'S SIGNATURE (PARENT/GUARDIAN)	WITNESS SIGNATURE
DATE	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. Further, the costs involved in my chiropractic treatment have been explained to me and I have agreed to said costs.

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 The Hillcrest Chiro within a reasonable time. I am further responsible to rectify/clarify any mistakes/errors made by the medical aid with the medical aid directly. The Chiropractor, The Hillcrest Chiro and it's staff 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 on any outstanding invoice, the Chiropractor 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;
If I do not settle 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 (PARENT/GUARDIAN)	WITNESS SIGNATURE
DATE	DATE

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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 the implications, risks and obligations, and confirm withdrawal of my consent for the following:

_____

PATIENT'S SIGNATURE (PARENT/GUARDIAN)	WITNESS SIGNATURE
DATE	DATE

ANNEXURE "A"

Please notify your chiropractor immediately should any side effects occur

MANIPULATION, MOBILIZATION AND TRACTION

This procedure involves movement of joints within their range of motion. 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

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

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.

TEMPERATURE THERAPY

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.

SOFT TISSUE THERAPY

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.

STRAPPING AND BRACING

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.