Neil Hopkins Biokineticist
Gardens Virgin Active, Wembley Square
0833001164
www.biokinetics.biz

CONSENT TO ASSESSMENT BY NEIL HOPKINS BIOKINETICIST AND ASSOCIATES.

(MUST BE SIGNED BY ALL PATIENTS OLDER THAN 12 YEARS)

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

I, _____, the undersigned, understand and declare that:

- During the evaluation I might need to uncover specific body parts, and I understand that I may refuse to do so if and when I do feel uncomfortable in doing so.
- I am aware that the biokineticist may need to touch me in order to perform a number of assessments and that I will inform the biokineticist if and when I feel uncomfortable.
- It is my right to withdraw this consent at any time or for any specific assessment.
- I have been informed of all the risks of the assessment.
- I have been informed of alternative treatment or interventions.
- I understand the need for the assessment and potential risks/complications.
- I am aware that I may stop the consultation at any time to discuss any concerns with the biokineticist.
- I furthermore grant any employee of Neil Hopkins Biokinetcist and Associates permission to arrange for the necessary medical assistance that may be required in case of injury or damage, should I be unable to do so myself.
- I hereby consent to the biokinetic assessment that will be performed on me / my dependant: subject to the biokineticist performing the relevant safety tests and evaluation, and taking relevant precautions.
- I have disclosed all my medical conditions, medications, and any other related information to the biokineticist.
- I understand that all information given to the biokineticist will be treated with the utmost confidentiality
- give this consent freely and declare that it was not made under duress.

_____ **Date:**_____/_____/_____

SIGNED: PATIENT / GUARDIAN IF PATIENT IS YOUNGER THAN 12

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CONSENT TO TREATMENT BY NEIL HOPKINS BIOKINETICIST AND ASSOCIATES.

(MUST BE SIGNED BY ALL PATIENTS OLDER THAN 12 YEARS)

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

I, _____, the undersigned, understand and declare that:

- During the treatment I will be trequired to do physical exercise.
- I might need to uncover specific body parts and I understand that I may refuse to do so if and when I do feel uncomfortable in doing so.
- The biokineticist may need to touch me in order to provide effective treatment and that I will inform the biokineticist if and when I feel uncomfortable.
- It is my right to withdraw this consent at any time or for any specific treatment or intervention.
- I have been informed of all the benefits and risks of the treatment and or intervention. I have been informed of alternative treatment or intervention
- I understand the treatment and potential complications and I have the opportunity to discuss this with the biokineticist.
- I furthermore grant any employee of Neil Hopkins Biokinetcist and Associates permission to arrange for the necessary medical assistance that may be required in case of injury or damage, should I be unable to do so myself.
- I hereby consent to biokinetic treatment and interventions that will be performed on me / my dependant: subject to the biokineticist performing the relevant safety tests and evaluation, and taking relevant precautions.
- I am willing to be assisted/trained by Neil Hopkins Biokineticist and/or one of his associates.
- I am willing for additional Biokineticists to shadow Neil Hopkins Biokineticist for educational purposes.
- I give this consent freely and declare that it was not made under duress.

_____ **Date:**_____/_____/_____

SIGNED: PATIENT / GUARDIAN IF PATIENT IS YOUNGER THAN 12

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CONSENT TO MANAGEMENT OF INFORMATION BY NEIL HOPKINS BIOKINETICIST AND ASSOCIATES

(MUST BE SIGNED BY ALL PATIENTS OLDER THAN 12 YEARS)

As part of of your **consultation and treatment** your information will need to be captured, stored and possibly shared.
This capturing and storing of information is essential in terms of the Health Professions Act and the HPCSA. The storage is compliant with the HPCSA guidleines and the sharing of information is compliant with the POPI act. You need to consent to this capturing, storing and sharing of information:

I, _____, the undersigned, do hereby give consent to Neil Hopkins Biokineticist and Associates 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 initial the options you give consent to:

Medical Scheme /Funder:	_____	Referring Doctor:	_____
Employer:	_____	Lawyer:	_____
School / Coach / Trainer:	_____	Other medical practitioners:	_____
Parents:	_____	Spouse:	_____
Children:	_____	Insurance Company:	_____
Other:	_____	Comp-solve (Only Injury on Duty):	_____

- 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.
- I indemnify Neil Hopkins Biokineticist and Associates 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 blameless of any further disclosures and or prejudice I may suffer as a result of such disclosures.
- I confirm that I have exercised my choice voluntarily and that this declaration and exercise of my choices was not made under duress.

_____ **Date:** _____ /_____/_____

SIGNED: PATIENT / GUARDIAN IF PATIENT IS YOUNGER THAN 12.

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CONSENT TO FINANCIAL RESPONSIBILITY TO NEIL HOPKINS BIOKINETICIST AND ASSOCIATES

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

I, _____, the undersigned, hereby accept full financial responsibility for the biokinetic assessment and treatment.

- I understand that I will be responsible for all legal fees involved, if legal action is needed to collect any outstanding fees.
- I hereby declare all personal and financial information as true and correct.
- Appointments not cancelled 24 hours before the time of appointment will be charged.
- This is a cash practice and treatments must be paid at time of consultation, unless otherwise arranged.
- Accounts will be rendered electronically. Please check all information and notify us as soon as possible of any changes or discrepancies.
- I am aware that Neil Hopkins Biokineticist is contracted out of medical aid.
- The consultation is a business transaction between the patient and the practitioner. Medical aid companies constitute a third party that is not directly involved in the provision of the Biokinetics service. It is therefore the patient's responsibility to deal with their medical aid, submit claims, and deal with queries.
- It is the patient's responsibility to clarify and rectify any mistakes made by the medical aid with the medical aid.
- Private fees are charged in accordance to medical aid rates.
- 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.
- 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.
- I declare that this consent was not made under duress.

_____ **Date:**____/____/_____

SIGNED: PERSON ACCOUNTABLE FOR ACCOUNT