PHYSIO WELLNESS
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TLOUBATLA ME INC
Bsc.Physio (MEDUNSA)

Pr. Number: 0479713

Reg No: 2012/180371/21
VAT No: 4280276090

Health Emporium
197 Market Street Midrand, 1682

DNA Consulting Suites
129 Rivonia Road Sandton, 2196

011 805 1433

info@physiowellnessclinic.co.za
www.physiowellnessclinic.co.za

PHYSIOTHERAPY INFORMED CONSENT

1. PATIENT **2. LEGAL GUARDIAN** (if applicable)

Names & Surname: _____ **Name & Surname:** _____

Identity number: _____ **Identity Number:** _____

1. Purpose of Physiotherapy Treatment

I understand that I am being referred for, or am seeking, physiotherapy services for the assessment, diagnosis, and management of:

(e.g. lower back pain, neck pain, sports injury, post-operative rehabilitation, injury recovery, neurological rehabilitation, chronic pain management, mobility improvement, or other specified conditions).

I understand that the overall aim of physiotherapy is to:

- Reduce pain and discomfort.
- Restore movement, strength, and function.
- Prevent recurrence or worsening of my condition.
- Promote overall physical well-being and quality of life.

Physiotherapy treatment may include, but is not limited to:

- **Manual therapy** (joint mobilisations, manipulations, stretching).
- **Soft tissue techniques** (massage, dry needling, myofascial release, trigger point therapy).
- **Electrotherapy** (e.g. Ultrasound, TENS, Interferential therapy, Laser therapy, Shortwave Diathermy).
- **Exercise prescription and rehabilitation** (individualised exercise programmes to improve strength, flexibility, posture, and balance).
- **Education** on self-management, posture, ergonomics, and lifestyle modifications.
- **Use of modalities or equipment** for treatment (e.g. heat, cold packs, resistance bands, gym equipment, assistive devices).

2. Risks and Benefits

I acknowledge that, before commencing physiotherapy treatment, I have been informed that:

- The physiotherapist will explain the nature, purpose, and expected benefits of the proposed treatment during my consultation.
- The potential benefits of physiotherapy may include, but are not limited to, pain relief, improved mobility, increased strength, better posture, enhanced function, and prevention of further injury.
- Possible risks and side effects may include (but are not limited to):
    - Temporary discomfort or pain during or after treatment.
    - Mild bruising or redness from manual therapy or dry needling.
    - Fatigue or mild dizziness after exercise.
    - Muscle soreness after physical activity.
- Rare but possible adverse effects may occur, and these will be discussed with me before any high-risk treatment is undertaken.
- No guarantees can be made regarding treatment outcomes, as results depend on individual circumstances, my participation, and other factors.
- I will have the opportunity to ask questions during my consultation, and all queries will be addressed before treatment begins.

3. Confidentiality and Privacy

I understand that:

- All my personal, medical, and treatment information will be kept **strictly confidential** in accordance with the **Protection of Personal Information Act (POPIA)** and other applicable laws.
- My records will only be accessed by my treating physiotherapist(s) and authorised practice personnel.
- My information will **only be shared** with third parties (e.g., medical practitioners, medical aid schemes, insurers) with my written consent, unless required by law, court order, or to protect my safety or that of others.
- I may request access to, or correction of, my personal records at any time.

4. Patient Rights and Responsibilities

I acknowledge that I: _____

Rights:

- Have the right to clear explanations about my condition and treatment options.
- May decline or stop any treatment at any time, without affecting my right to future care.
- May request a second opinion or referral if I wish.

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Responsibilities:

- Will inform the physiotherapist of any changes in my health, medications, or symptoms that may affect treatment.
- Will follow treatment plans, exercise programmes, and safety instructions as advised.
- Will attend all scheduled sessions, or notify the practice at least 24 hours in advance if I need to cancel.
- Will treat all staff with respect and engage in open, honest communication.

5. Consent to Treatment

I confirm that:

- I have read and understood all the above information.
- I have had the opportunity to discuss my condition, treatment options, and any concerns with my physiotherapist.
- I voluntarily consent to physiotherapy **assessment and treatment** as proposed.
- I understand that I may withdraw my consent at any stage, verbally or in writing, without any negative effect on my right to care.

6. Consent for Student or Assistant Involvement

(Please tick one)

☐ I consent to being treated or observed by a supervised physiotherapy student or assistant.
☐ I do not consent to student or assistant involvement.

7. Consent for Electronic Communication

I consent to receiving appointment reminders, medical reports, or follow-up communications via:
☐ SMS ☐ Email ☐ WhatsApp. ☐ I do not consent to electronic communication.

8. Signature

Signed and dated at_____ on _____dayof_____20_____

Patient/Legal Guardian

_____

Witness

Note: This consent remains valid for the duration of treatment but may be reviewed or withdrawn at any time. A copy will be provided upon request.

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AGREEMENT BETWEEN TLOUBATLA ME INC AND PERSON RESPONSIBLE FOR THE ACCOUNT

PERSON RESPONSIBLE FOR THE ACCOUNT:

Name & Surname: _____

Identity Number: _____

Physical Address: _____

I, the responsible person hereby agrees as follows:

1. I am liable for payment of all medical services delivered by any therapist of TLOUBATLA ME INC (the practice) to the patient _____ the extent that it is applicable; I am the parent/legal guardian of the patient.
2. I will pay the account of the practice in full promptly and in accordance with the tariff of charges prevailing in the practice, or as agreed upon with the practice, irrespective of contracts/ agreements I may have with the medical scheme or any third party.
3. Tariffs are charged in line with the medical aid tariff, according to the treatment provided. Treatment after hours (after 6 PM on weekdays) on weekends and public holidays are charged at an additional of 50% of the full fee.
4. Should the practice institute legal actions against me for the recovery of any outstanding debts, I agree to pay all legal cost (including Attorney Client scale and own client costs, collection fees and tracing fees).
5. I acknowledge that, in accordance with the provision of Section 53(1) of the Health Profession Act of 1974 (duty amended) and Section 6(C) of the National Health Act 61 of 2003, the costs associated with all physiotherapy services, treatment and/or procedures has been discussed and fully explained to me and/or the patient to the extent required by law and professional ethics.
6. It is a medical requirement to provide ICD-10 codes to your Medical Aid for funding and by providing such codes to the Medical Aid, switching companies and administrator responsible for the account will be familiar with your diagnoses for purposes of processing of payment of account in respect of physiotherapy services delivered to the patient. The patient and/or myself have been informed that in certain circumstances, such as disclosure of ICD-10 codes, the exact consequences of disclosing such information is unknown to the practice and that information relating to these consequences must be obtained by myself and/or the patient

from the third party to whom the information is disclosed. Should I wish not to disclose the ICD-10 codes, I will be liable to settle the account.

7. The practice will do everything in their power to protect my information whole in the practice but cannot be liable for protecting an information once it has left the practice
8. The practice may:
   a. Make inquiries to confirm any information provided by the patient or myself
   b. Seek information from any credit bureau when assessing my application for credit at any time during my continuing indebtedness to the practice or tracing my whereabouts.
   c. Disclose the existence of my account to any credit bureau, sharing both positive and negative payment information about such account
9. The practice will be entitled to obtain and disclose any of the above-mentioned information.
   a. If the practice consider that it is necessary or may be of benefit to the patient and/or myself.
   b. Where a physiotherapist has a legal obligation to do so.
   c. Where it is the practice's own or public interest that the practice does so

Signature

Signed and dated at_____ on _____day of_____20_____

_____

Patient/Legal Guardian

_____

Witness