CONSENT TO BIOKINETIC TREATMENT AND THE RELEASE OF INFORMATION

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

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

- During the treatment and 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.
- 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 had the opportunity to discuss this with the biokineticist.
- I further more grant any employee of _____(practice name) 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 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.
- I have been informed that the practice is accredited with the HPCSA as a training facility for students in Biokinetics. Service might therefore be rendered by Biokinetic students or interns.
- I give this consent freely and declare that it was not made under duress.

I, _____, the undersigned, do hereby give consent to

_____(practice name) 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 tick the boxes that you do give consent to:

	YES	NO
Medical Scheme /Funder:		
Employer:		
School / Coach:		
Parents:		
Children:		
Other:		

	YES	NO
Referring Doctor:		
Lawyer:		
Other medical practitioners:		
Spouse:		
Insurance Company:		
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 confirm that I have exercised my choice voluntarily and that this declaration and exercise of my choices was not made under duress.

I indemnify _____(practice name) 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.

_____ Date: _____/_____/_____

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