Dr.
VICKI FERREIRA
CHIROPRACTOR

Dr Vicki Ferreira Chiropractor **Practice Number: 0680303**
M.Tech (UJ) **AHPCSA: A11834**

PATIENT INFORMATION			
ID NUMBER		DATE OF BIRTH	
SURNAME		FULL NAME(S)	
PREFERRED NAME	TITLE	MARITAL STATUS	OCCUPATION
RESIDENTIAL ADDRESS (chosen address/Domicilium citandi)			
EMAIL		CELLPHONE	
PERSON RESPONSIBLE FOR ACCOUNT (IF NOT PATIENT)			
ID NUMBER		DATE OF BIRTH	
SURNAME		FULL NAME(S)	
POSTAL ADDRESS		RESIDENTIAL ADDRESS (chosen address/Domicilium citandi)	
EMAIL		CELLPHONE	
CLOSEST FRIEND OR RELATIVE			
SURNAME		FULL NAME(S)	
CELLPHONE NUMBER		RELATIONSHIP	

MEDICAL AID PATIENTS

Ensure the receptionist has made a copy of your medical aid card if you prefer this method of payment.

MEDICAL AID SCHEME	MAIN MEMBER NAME
PLAN/OPTION	MAIN MEMBER ID NUMBER
MEMBERSHIP NUMBER	PATIENT DEPENDANT NUMBER

- The treatment costs are in accordance to the National Referencing Price List (NRPL), i.e. these are medical aid rates; no co-payment is required. In the case where a medical aid does not pay out, the person responsible for the account must then settle the outstanding amount within 30 days of treatment date. **An admin fee of 10% will be added to my account for every month that my account is outstanding.**
- I understand that the practice is entitled to charge me personally **R300**, should I miss my appointment or cancel in less than 24 hours in advance. **This amount cannot be claimed form the medical aid and is my responsibility and to be paid within 1 week**.

Initial: _____

AGREEMENT

1. The patient, or his or her guardian, hereby consents to:-

   1.1. the performance of chiropractic treatment, now and in the future, by the chiropractor and/or anyone registered as chiropractor working in this office/practice;

   1.2. the evaluation of his or her health status by means of an interview and/or the performance of clinical tests in order to diagnose his or her condition and to determine any contraindication to treatment;

   1.3. The disclosure of his or her diagnosis to the medical schemes, other medical professionals and support staff in the employ of the practice for purpose of reimbursement and/or settlement of any account, administrative tasks and/or referral.

2. The patient, or his or her guardian, acknowledges that:-

   2.1. He or she has the right to have a person of his or her choosing present during certain physical examinations;

   2.2. He or she has the right not to remain disrobed longer than is required for accomplishing the examination;

   2.3. There are certain risks involved with chiropractic treatment. The following side effects may be experienced:

      2.3.1. Minor: mild to moderate discomfort, autonomic phenomena such as dizziness, headaches and post treatment discomfort;

      2.3.2. Severe (extremely rare): fractures, dislocations, disc herniation or progression of neurological symptoms and stroke.

   2.4. This practice may utilize other chiropractic treatments such as: needling therapy, electrotherapy, temperature therapy, soft tissue therapy, strapping and bracing. The risks association with these therapies include:

      2.4.1. bleeding, bruising, infection, lung puncture, pain, autonomic phenomenon such as dizziness and nausea, burns, electrocution, skin irritation and discomfort and discomfort.

   2.5. This consent will be binding towards current and future treatment, regardless if the patient's condition changes during the course of treatment;

   2.6. He or she has the right to withdraw consent at any time for any specific procedure and/or treatment;

   2.7. The information provided are both true and correct and should any personal information, such as address, change the patient, or his or her guardian, will notify the practice of such within 7 (seven) days;

   2.8. The chiropractor and/or any their employees, agents or anyone temporarily in their service will not disclose any personal or medical information to any third party without the written consent of the patient, or his or her guardian, except for as set out above in paragraph 1.3.

   2.9. Access to the premises of the chiropractor and the use of the facilities are done at his or her own risk and the patient, or his or her guardian, indemnifies the owner of the premises, the chiropractor and/or their employees, agents or anyone temporarily in their service for any damage, loss and/or injury sustained on or at the premises;

3. In the event of the patient experiencing any side effects, the patient, or his or her guardian, **must** immediately notify the chiropractor. Failure to raise any concern will create the assumption that the patient is satisfied with the service provided and further indicated that he or she is not experiencing any side effects to the treatment provided;

4. The undersigned accepts full financial responsibility and liability to settle all accounts in full. In the event of the practice having to claim from a medical scheme, the undersigned acknowledges that there is no obligation on the medical aid to settle the account in full and the undersigned will remain liable for any account not settled or partially settled by the medical aid for whatsoever reason.

5. In the event of any injury on duty, it is the responsibility of the patient, or his or her guardian, to submit the necessary documentation within 10 (ten) days after the starting date of treatment, and should the patient, or his or her guardian, fill to submit same, they will become liable fo the full amount due;

6. The undersigned further acknowledges that he or she will be liable for all legal fees incurred on an attorney own client scale in the enforcement of this agreement or the collection of any debt unpaid by the undersigned, inclusive of administration cost for late payment and interest payable;

7. The undersigned further appoints as his or her *domicilium citandi et executandi* (chosen address) where all legal documents and notices may be sent, the address as set out above and should same change he or she will notify the practice within 7 (seven) days of any such change;

8. In the case of a minor receiving treatment, the legal guardian will sign for consent of treatment.

I, (full name and surname)_____ confirm that I have read the above information and give my informed consent to begin treatment. I have also supplied the practice with the correct information.

SIGNATURE	DATE	ID NUMBER

PLEASE COMPLETE YOU MEDICAL HISTORY ON THE NEXT PAGE

MEDICAL HISTORY

Has the Patient Recently Experienced Any of the Following Symptoms?	No	Yes	Specify
Pain			
Fever			
Chronically Unwell			
Tiredness			
Stress			
Polyuria (excessive urine production)			
Polydipsia (excessive thirst)			
Dizziness			
Severe Headaches			
Weakness (without pain)			
Night Sweats			
Loss of Bladder or Bowel Control			
Sudden Weight Loss			
Weight Problems			
Desire to Lose Weight			
Do You Smoke? How many per day?			
Destinations of Recent Travels (Malaria areas, Vaccine areas)			
Chronic Infections			
History of Physical Trauma / Abuse			
Has a Personal or Family History of:			Grandmothers(GM), Grandfathers(GF), Mother(M), Father(F), Brother(B), Sister(S), Self(PT)
Rheumatoid Arthritis			
Congenital Spinal Anomalies (Born with Deformity)			
Multiple Sclerosis			
Ankylosing Spondylitis			
Psoriasis			
Cancer			
Osteoarthritis			
Osteoporosis			
Gout			
High Blood Pressure			
Stroke			
Diabetes Mellitus			
Connective Tissue Disorder (eg. Marfans, Ehlers-Danlos, etc.)			
Other (eg. Cholesterol, Thyroid, Eczema, etc.)			
Using Any Chronic Medication? Incl. vitamins, supplements			
Allergies?			