Carren Hughes
PHYSIOTHERAPIST

HPCSA Number: PT0076384

Practice Number: 720000251526

Practice Policies and Patient Consent

This practice offers specialist services devoted to the many functions and dysfunctions of the pelvis. Assessment and treatment is complex and complicated. involving multiple systems. The focus is on accurate assessment to inform appropriate treatment.

Cancellation Policy

Cancellations to be made no later than 17h00 (5pm) the day before. In the event of a same day cancellation, every effort will be made to fill the slot (no charge), however if we are unable to do so a cancellation fee of R500 for un-kept appointments will be charged. Please cancel appointments directly to the practice phone **0823270266** . Text messages and emails are not considered adequate notice due to the high failure rate (I am in consultations with patients). **Insist on a confirmed cancellation.**

Consent to payment

This practice is a **cash practice.** Settlement is on the day. Payment via credit card, debit card, cash or immediate EFT.

Initial Consult 60 mins R780 - R850 (at times a longer period is necessary, this will be discussed by the therapist)

Follow-up consults 45mins - 60 mins R710 - R760

30mins R650

Costs are approximate, due to specific billing codes used based on assessment and treatment modalities required.

This Practice will not be involved in any Medical Aid/Funder disputes.

I consent to settle my account directly and submit to my medical aid/funder for reimbursement myself YES / NO

I consent to settle all outstanding fees due as a result of late payment of my account YES / NO

Consent to Patient Information usage

As a registered healthcare provider, we are required by law to follow the standards detailed by the Health Professions Council of South Africa (HPCSA) which dictates professional conduct and ethics, including managing the privacy and security of patients and their health information. Your confidentiality, dignity and privacy are of the utmost importance to us.

Please indicate how we may share your information here. Note that if you do not disclose relevant information with your medical aid they will reject your claim.

I consent to relevant information being shared with my medical aid. Namely: ICD 10 codes; treatment codes; treatment frequency and comorbidities. YES / NO

I consent to my case being discussed in a multidisciplinary team context YES / NO

I consent to relevant information being shared with the multidisciplinary team YES / NO

I consent to my information being shared with other healthcare providers YES / NO

Namely: ………

I consent to my information being shared with non-medical contacts YES / NO

Namely: ………

Consent to process personal information

I acknowledge that my personal information needs to be processed by the practice and therefore grant the following consent:

I acknowledge and accept that the medical practice will during the course of rendering services to me, collect and have access to my personal information, including information relating to my race, gender, sex, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language, identifying number and my biometric information.

I grant my express consent for the practice to collect and process this information for the purpose of rendering services to me as wel as processing claim with medical schemes or insurance funders.

Administrative staff employed in the practice may be granted access to my personal information contained in my health record, including any clinical notes, in order to process claims to medical schemes, issuing of documentation or any other administrative function required by the practice.

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The practice makes use on an online Cloud based medical billing system called Heromed and I grant my consent to the process of my personal information by Heromed (Pty) Ltd (including its employees) as is required to process claims with medical schemes.

I accept that my personal information will be accessed and processed by my medical scheme and/or health insurer and grant the practice and Heromed (Pty) Ltd consent to transmit that informationas required to process any claims.

Name of patient …….

Signature of patient ………

Signature of parent or guardian …………………………………………………………………………………………….

Name of Physiotherapist Carren Hughes

Signature of Physiotherpist ……………………………………………………………………………………………………

Signed at ………..Riverclub / Hospital……………. on ………………………………………………………(date)

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