StepMed

Paramedical Centre

StepMed Rehab (PTY) LTD 2015M87233/07

Nel, Kruger & Associates Inc	Mariaan Teubes	Lourens
Physiotherapy	Occupational Therapy	Speech Therapy & Audiometry
Prac nr. 0556874	Prac nr. 0378585	Prac nr: 0339253

CONSENT FOR MULTIDISCIPLINARY TREATMENT IN HOSPITAL/FRAILCARE

Name__________________________________ID.________________________________Date__________________

Email_________________________________ Signature____

In my capacity as competent person (parent, legal guardian or a legal representative appointed by a court to manage the finances, property, or estate of person unable to do so because of mental or physical incapacity.), I declare I have authority to give consent on behalf of:

Name of patient___________________________________ID.____

I hereby give consent to treatment to: (please tick)

- ☐ The Physiotherapy practice of Nel, Kruger and Associates Inc
- ☐ The Occupational Therapy practice of Mariaan Teubes,
- ☐ The Speech Therapy Practice Lourens Speech Therapy & Audiometry

TRADING AS STEPMED REHAB (PTY) LTD

- ☐ I/we am aware of Stepmed Rehab (PTY) Ltd POPIA statement.
  For more info email info@stepmed.co.za or visit our website www.stepmed.co.za
- ☐ I/we give consent that only relevant personal information will be processed (diagnosis, medical condition, clinical notes and patient diary) and may be shared between the above-mentioned practices to enhance the quality of care.
- ☐ I/we am/are aware of the purpose for which the personal information is being collected.
- ☐ I/ we will take reasonably practicable steps to ensure that the personal information shared with the above practices is complete, accurate, not misleading and updated where necessary, taking into account the purposes for which it was collected.
- ☐ I/we give permission that the information stipulated above may also be *shared* with a third party (switching house/medical aid for account processing) or *requested* from a third party (other relevant medical practitioners e.g., radiologist) to enhance the quality of care provided. In these circumstances, the further processing will be compatible with the purpose for which it was initially collected.
- ☐ I/we understand that STEPMED REHAB (PTY) LTD will secure the integrity of personal information in our possession and control by taking prescribed measures to prevent loss of, damage to or unauthorised destruction of personal information and unlawful access to or processing of personal information.
- ☐ I/we have the right to request STEPMED REHAB (PTY) LTD party to confirm whether or not STEPMED REHAB (PTY) LTD holds personal information about the above-mentioned patient and request the record or a

description of the personal information held, including information about the identity of all third parties, or categories of third parties, who have, or have had, access to the information.

- ☐ I/we understand that STEPMED REHAB (PTY) LTD will correct or delete personal information about the above-mentioned patient in its possession or under its control that is inaccurate, irrelevant, excessive, misleading or obtained unlawfully; or destroy or delete a record of personal information about the above-mentioned patient that STEPMED REHAB (PTY) LTD is no longer lawfully authorised to retain.
- ☐ I/we confirm that I/we understand the proposed treatment as discussed with me/us as well as the nature, benefits, risks and complications.
- ☐ I/we had sufficient opportunity to consider whether I/we want to proceed with the proposed treatment.
- ☐ I/we therefore freely and voluntarily agree to the proposed treatment.
- ☐ I/we hereby consent to remove any clothing deemed necessary to receive effective treatment.
- ☐ I/we understand that during therapy, the therapist will need to make physical contact with the patient, to provide effective treatment.
- ☐ I/we understand that all reasonable care will be taken by the relevant treating therapists to prevent/limit the transference of any/all infectious diseases.
- ☐ I/we hereby give consent that the therapist and / or the format of the treatment can change at any time.
- ☐ I/we give consent to the taking of photographs or video recordings which may be necessary in the assessment and the compiling of an exercise program. These will only be used for clinical information and may be necessary to share with the doctor or other relevant Therapists.
- ☐ It is further understood that this consent can at any time be withdrawn and that personal and medical information will thereafter not be processed other than for payment purposes for treatment/services rendered / received.
- ☐ I/we, hereby voluntarily and without coercion, give permission to STEPMED REHAB (PTY) LTD to provide the necessary essential therapy services in Hospital/Frail care.

WHO MAY GIVE CONSENT?

- Major patients (patients over the age of 18 yrs.) with sufficient mental capacity: Independent consent for all medical care, including operations.
- Major patients with sufficient mental capacity but unable to consent: Person mandated in writing, spouse/partner, parent, grandparent, adult child, brother or sister, another person authorized by law, court.
- Patients with insufficient mental capacity due to cognitive impairments: Person mandated in writing, spouse/partner, parent, grandparent, adult child, brother or sister, another person authorized by law, court.
- Patients over the age of 12 years with sufficient mental capacity: Independent consent for medical treatment (excluding HIV testing). Parents or legal guardians or another person authorized by law must consent to operations.
- Patients under the age of 12 years and other minor patients with insufficient mental capacity: Parents or legal guardians or another person authorized by law for all medical care (excluding HIV testing) and operations.

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RESPONSIBILITY FOR ACCOUNT

Name_________________________________ID._________________________________Date__________________

Email__________________________________Signature____

In my capacity as competent person (parent, legal guardian or a legal representative appointed by a court to manage the finances, property, or estate of person unable to do so because of mental or physical incapacity.), I declare I have authority to give consent on behalf of:

Name of patient____________________________________ID.____

I hereby give consent for administrative/billing purposes to: (please tick)

- ☐ The Physiotherapy practice of Nel, Kruger and Associates Inc
- ☐ The Occupational Therapy practice of Mariaan Teubes,
- ☐ The Speech Therapy Practice Lourens Speech Therapy & Audiometry

- ☐ I/we am/are aware that STEPMED REHAB (PTY) LTD consists of the three distinct, separate disciplines as set out above, and will receive three separate accounts from each of these disciplines where services were rendered, and not from STEPMED REHAB (PTY) LTD.
- ☐ I/we give consent to the Multidisciplinary practice of STEPMED REHAB (PTY) LTD to divulge personal and relevant medical information to administrative staff concerned with purposes of obtaining medical aid authorisation and payment, which includes the sending of an agreed upon account to the relevant third-party payer if applicable. Such access to personal information will be on a need-to-know basis.
- ☐ I/we give consent that ICD10 codes be supplied to the medical scheme for purposes of reimbursements.
- ☐ I/we understand that the patient’s confidentiality will be protected at all costs.
- ☐ I/we understand that I/we am/are personally responsible for the payment of this account and NOT the medical aid and hereby accept full financial responsibility for this account until it is settled in full.
- ☐ I/we understand that the multidisciplinary practice of STEPMED REHAB (PTY) LTD will not get involved in any medical aid disputes.
- ☐ I/we understand that I/we will be liable for all legal costs on attorney and client scale, collection charges and tracing fees, should the account be handed over for any monies in arrears.
- ☐ I/we understand that Stepmed Rehab (PTY) Ltd charges medical aid rates.

- [ ] I/we understand that private patient accounts need to be settled in full on day of service or as negotiated with the relevant practice.
- [ ] I/we understand that due to the nature of our business, price estimates given prior to procedures may vary to the actual total received at the end of the procedure.
- [ ] I/we hereby declare that the billing procedures of this practice have been discussed with me and that I/we understand the conditions and implications thereof.
- [ ] I/we hereby declare all personal and financial information as true and correct.