Neil Hopkins Biokineticist & Associates
Gardens Virgin Active, Wembley Square,
McKenzie St., Gardens, Cape Town, South Africa
083 300 1164
neil@biokinetics.biz
www.biokinetics.biz

BIOKINETICS

INFORMED CONSENT

Neil Hopkins Biokineticist & Associates
Gardens Virgin Active, Wembley Square,
McKenzie St., Gardens, Cape Town, South Africa
083 300 1164
neil@biokinetics.biz
www.biokinetics.biz

CONSENT TO ASSESSMENT *(MUST BE SIGNED BY ALL PATIENTS OLDER THAN 12 YEARS)*

As part of your **consultation** you will need to undergo some form of physical assessment. This physical assessment is essential to determine the nature/cause of your injury and/or to determine your level of fitness, strength, flexibility, balance, endurance, etc. You need to consent to this assessment:

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

1. I am aware that during the evaluation I might need to uncover specific body parts, and I understand that I may refuse to do so if and when I feel uncomfortable.
2. I am aware that the biokineticist may need to touch me in order to perform a number of assessments and that I will inform the biokineticist if and when I feel uncomfortable.
3. I am aware that it is my right to withdraw this consent at any time or for any specific assessment.
4. I have been informed of the potential risks of doing a physical assessment.
5. I have been informed of alternative assessments, treatment options or interventions.
6. I understand the need for the assessment and potential risks/complications.
7. I am aware that I may stop the consultation at any time to discuss any concerns with the Biokineticist.
8. I hereby consent to the biokinetic assessment that will be performed on me / my dependent: subject to the biokineticist performing the relevant tests and evaluations along with taking relevant safety precautions.
9. I have disclosed all my medical conditions, medications, and any other related information to the biokineticist.
10. I understand that all information given to the biokineticist will be treated with the utmost confidentiality.
11. In case of emergency: I furthermore grant Neil Hopkins Biokineticist and / or an associate of his, and / or support staff permission to arrange for the necessary medical assistance that may be required in case of injury or emergency, should I be unable to do so myself.
12. I am aware that it is my responsibility to provide written evidence of any DNR arrangements, and that these may be ignored by emergency personnel according to South African legislation.
13. I give this consent freely and declare that it was not made under duress.

_____ **Date:**_____/_____/_____

SIGNED: PATIENT / GUARDIAN IF PATIENT IS YOUNGER THAN 12

Neil Hopkins Biokineticist & Associates
Gardens Virgin Active, Wembley Square,
McKenzie St., Gardens, Cape Town, South Africa
083 300 1164
neil@biokinetics.biz
www.biokinetics.biz

CONSENT TO TREATMENT *(MUST BE SIGNED BY ALL PATIENTS OLDER THAN 12 YEARS)*

As part of your **treatment** you will need to undergo some form of physical exercise. This physical exercise is essential to address the nature/cause of your injury and/or to improve your level of fitness, strength, flexibility, balance, endurance, etc. You need to consent to this treatment:

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

1. I am aware that during the treatment I will be required to do physical exercise.
2. I am aware that might need to uncover specific body parts during follow up assessments and I understand that I may refuse to do so if and when I feel uncomfortable.
3. I am aware that the biokineticist may need to touch me to provide tactile cues in order to provide effective treatment and that I will inform the biokineticist if and when I feel uncomfortable.
4. I am aware that it is my right to withdraw this consent at any time or for any specific treatment or intervention.
5. I have been informed of the benefits and risks of the treatment and or intervention. I have also been informed of alternative treatments / interventions.
6. I understand the treatment and potential complications and I have the opportunity to discuss these.
7. I hereby consent to biokinetics treatment / interventions that will be performed on me / my dependent: subject to the biokineticist performing the relevant tests and evaluations, along with taking relevant safety precautions.
8. I am willing to be assisted / trained by Neil Hopkins Biokineticist and / or one of his associates.
9. I am willing for additional biokineticists to shadow Neil Hopkins Biokineticist for educational purposes.
10. In case of emergency: I furthermore grant Neil Hopkins Biokineticist and / or an associate of his and / or support staff permission to arrange for the necessary medical assistance that may be required in case of injury or emergency, should I be unable to do so myself.
11. I am aware that it is my responsibility to provide written evidence of any DNR arrangements, and that these may be ignored by emergency personnel according to South African legislation.
12. I give this consent freely and declare that it was not made under duress.

_____ **Date:**_____/_____/_____

SIGNED: PATIENT / GUARDIAN IF PATIENT IS YOUNGER THAN 12

Neil Hopkins Biokineticist & Associates
Gardens Virgin Active, Wembley Square,
McKenzie St., Gardens, Cape Town, South Africa
083 300 1164
neil@biokinetics.biz
www.biokinetics.biz

CONSENT TO MANAGEMENT OF INFORMATION *(MUST BE SIGNED BY ALL PATIENTS OLDER THAN 12 YEARS)*

As part of your **consultation and ongoing treatment** your information will need to be captured, stored and possibly shared. Ethically and legally appropriate capturing, sharing and storing of information is essential in terms of the National Health Act, the Health Professions Act (and the HPCSA guidelines), the Public Access to Information Act, and the Protection of Personal Information Act. The capturing, storing and sharing of information needs to be compliant with the abovementioned legislation and you need to consent to the capturing, storing and sharing of your personal information, your medical results, your medical history, information necessary for financial statements / medical aid claims:

I, _____, the undersigned, do hereby give consent to Neil Hopkins Biokineticist 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 initial the options you give consent to)

Medical Scheme / Funder:	_____	Doctor / medical professional	_____
Employer:	_____	Lawyer:	_____
School / Coach / Trainer:	_____	Insurance Company:	_____
Parents / children:	_____	Spouse / partner:	_____

1. I fully understand that this is a legal requirement and that I have a choice <u>not to</u> consent to such information being disclosed to any party.
2. I indemnify Neil Hopkins Biokineticist 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 associates blameless of any further disclosures and or prejudice I may suffer as a result of such disclosures.
3. I confirm that I have exercised my choice voluntarily and that this declaration and exercise of my choices was not made under duress.

_____ **Date:** _____ **/**_____**/**_____

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

Neil Hopkins Biokineticist & Associates
Gardens Virgin Active, Wembley Square,
McKenzie St., Gardens, Cape Town, South Africa
083 300 1164
neil@biokinetics.biz
www.biokinetics.biz

CONSENT TO DIGITAL COMMUNICATION *(MUST BE SIGNED BY ALL PATIENTS OLDER THAN 12 YEARS)*

As part of your **consultation and ongoing treatment** it may be required to communicate using digital / electronic / distance / non-face-to-face / telemedicine platforms as a method of communication. It is important to acknowledge that face-to-face care is the best form of care, however it is not always practical or possible.

Patient-practitioner communication via digital / electronic / distance / non-face-to-face / telemedicine needs to be compliant with the National Health Act, the Health Professions Act (and the HPCSA guidelines), the Public Access to Information Act, and the Protection of Personal Information Act. Ethically and legally appropriate capturing, sharing and storing of information still applies to patient-practitioner communication via digital / electronic / distance / non-face-to-face / telemedicine platforms. Your patient information will need to be captured, stored and possibly shared using third-party platforms (Gmail, WhatsApp, Skype, DropBox, Xero, etc.). The PAIA and POPIa require that these third-party platforms are located in countries that have similar or better privacy legislation than South Africa.

The capturing, storing and sharing of information needs to be compliant with the abovementioned legislation and you need to consent to the use of third-party platforms involved in the digital / electronic / distance / non-face-to-face / telemedicine correspondence. These third-party platforms may play an indirect role in the capturing, storing and sharing of your personal information, your medical results, your medical history, information necessary for financial statements / medical aid claims.

1. I fully understand that this is a legal requirement and that I have a choice not to consent to such information being disclosed to / via any third-party.
2. I indemnify Neil Hopkins Biokineticist 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 associates blameless of any further disclosures and or prejudice I may suffer as a result of such disclosures.
3. I confirm that I have exercised my choice voluntarily and that this declaration and exercise of my choices was not made under duress.

_____ **Date:** _____ **/**_____**/**_____

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

Neil Hopkins Biokineticist & Associates
Gardens Virgin Active, Wembley Square,
McKenzie St., Gardens, Cape Town, South Africa
083 300 1164
neil@biokinetics.biz
www.biokinetics.biz

CONSENT TO FINANCIAL RESPONSIBILITY

It is important to note that there is a cost involved with the Biokinetics services offered by Neil Hopkins Biokineticist, and patients are under financial obligation to pay. The initial Biokinetics consultation and follow up consultations vary in cost depending on the service required.

I, _____, the undersigned, hereby accept full financial responsibility for the biokinetic assessment and treatment.

1. I am aware that there is a cost involved (fee for service), the cost is my responsibility and I am under financial obligation to pay.
2. I hereby declare all personal and financial information as true and correct.
3. Appointments not cancelled 24 hours before the time of appointment will be charged.
4. This is a cash practice and treatments must be paid at time of consultation, unless otherwise arranged.
5. Accounts will be rendered electronically. Please check all information and notify us as soon as possible of any changes or discrepancies.
6. I am aware that Neil Hopkins Biokineticist is contracted out of medical aid.
7. The consultation is a business transaction between the patient and the practitioner. Medical aid companies constitute a third party that is not directly involved in the provision of the Biokinetics service. It is therefore the patient's responsibility to deal with their medical aid, submit claims, and deal with queries.
8. It is the patient's responsibility to clarify and rectify any mistakes made by the medical aid with the medical aid.
9. Private fees are charged in accordance to medical aid rates.
10. Accounts older than 30 days will be followed up with a telephone call, SMS or e-mail.
11. Accounts older than 60 days will receive a final written warning.
12. If still not settled within 14 days after the final warning date, the account will be handed over for legal action.
13. I understand that I will be responsible for all legal fees involved, if legal action is needed to collect any outstanding fees.
14. I hereby declare that the billing procedures of this practice have been discussed with me and that I do understand the conditions and implications thereof.
15. I declare that this consent was not made under duress.

_____ **Date:**____/____/_____

SIGNED: PERSON ACCOUNTABLE FOR ACCOUNT

Neil Hopkins Biokineticist & Associates
Gardens Virgin Active, Wembley Square,
McKenzie St., Gardens, Cape Town, South Africa
083 300 1164
neil@biokinetics.biz
www.biokinetics.biz

PROTOCOL IN THE CASE OF DISPUTE *(MUST BE SIGNED BY ALL PATIENTS OLDER THAN 12 YEARS)*

If you feel at any point during your **consultation and / or ongoing treatment** that there has been negligence or that a negligent act / omission has resulted in harm then you are entitled to report the matter to the HPCSA or to seek legal representation.

Once you / your legal representative has lodged an appeal / claim all correspondence between patient and practitioner needs to discontinue. This is a requirement stipulated by medical malpractice insurance brokers / underwriters. If you decide to seek legal advice, then all correspondence needs to take place via the insurance broker / underwriting company / legal representation appointed to the medical professional.

In these circumstances your medical history, patient notes and informed consent needs to be shared with the insurance brokers, the underwriters, and / or any appointed legal representative. These documents will be used in determining the merits of the case and may be relied on in court.

1. I fully understand that this is a legal requirement and I fully consent to such information being disclosed to any third-party that is legally necessary in the claims process.
2. I confirm that I have exercised my choice voluntarily and that this declaration and exercise of my choices was not made under duress.

_____ **Date: _____ /_____/_____**

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

Neil Hopkins Biokineticist & Associates
Gardens Virgin Active, Wembley Square,
McKenzie St., Gardens, Cape Town, South Africa
083 300 1164
neil@biokinetics.biz
www.biokinetics.biz

COVID-19 RISK INFORMED CONSENT *(MUST BE SIGNED BY ALL PATIENTS OLDER THAN 12 YEARS)*

I _____ the undersigned understand that I am opting for **elective** biokinetics treatment.

1. I have been **given the option to defer my treatment to a later date or via an online telehealth consultation**. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and **I would like to proceed with my desired treatment despite the COVID-19 risk.**
2. I understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. **I further understand that COVID-19 is extremely contagious** and is believed to spread by person-to-person contact; and, as a result the South African Government and international health agencies recommend social distancing.
3. I understand that, even if I have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment can lead to a higher chance of complication and in extreme circumstances death.
4. **I understand that possible exposure to COVID-19 before/during/after my treatment may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.**
5. I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.
6. I recognize that Neil Hopkins Biokineticist has been closely monitoring this situation and has put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, **I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment**.
7. **I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and I give my express permission for Neil Hopkins Biokineticist to conduct treatment at my request.**

_____ **Date:** _____ **/**_____**/**_____

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