CHERYL FISHER
OCCUPATIONAL THERAPISTS

TERMS AND CONDITIONS OF THERAPY AT THE KEY SCHOOL

Being a patient at this practice means that you are subject to the following, which applies every time your child is seen for therapy at the school:

Medical aids / medical schemes

1. This practice is contracted to a selection of medical aids and as such we **will** submit the account on your behalf if you are a member of one of those schemes. If you are not a member of one of these schemes it is your responsibility to settle the account directly with your therapist, and then claim back from the medical scheme.

2. Medical aids sometimes pay less than what we charge. Sometimes they do not pay at all. **Note that you will still have to pay the full account.**

What we charge

3. A list of our current consultation fees that you have to pay if you get therapy at this practice can be found on the website www.cherylsot.co.za. The agreed cash rates for therapy at the Key School are listed below, fees may change from time to time and are increased annually. Should we be billing to your medical aid their rates will be used. C fees for 2017 are as follows:
    - Full Assessment fee (including report and feedback session) – R2300
    - 50 minute Individual therapy session – R530
    - 30 minute Individual therapy session – R340

4. In some cases we need to do something different or something more in order to help you (home programmes, team meetings, progress reports etc). In such cases we will are able to provide you with a quotation, on your request, that will state what we estimate the cost would be, but also what could make the quotation go up, or down. **If you are uncertain of a quotation or fee, please talk to your therapist about the cost of your therapy**.

5. The cost of materials that we use during therapy may differ and we will in each case inform you of the cost thereof, if it is not included in the consultation fee.

Initial:_____

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When you have to pay

6. Cash clients:
   6.1. Accounts will be sent via email, unless otherwise requested, in the last week of each month.
   6.2. You must **pay us within 7 days** (one week) after you have received your account. You can pay in cash at the practice, or make an internet banking transfer (EFT) – our bank details are on the account. We regret we do not accept any cheques or credit cards.
   6.3. If you do not pay us an administration fee of R100 per month will be levied after 60 days on all amounts in arrears.

7. Medical aid clients:
   7.1. Accounts will be submitted every 2 weeks on average depending on the payment run for your medical aid
   7.2. Should your medical savings be depleted your payment terms revert to that of a cash client listed in clause 6 above

What could happen if you do not pay us in time

8. If you do not pay us within the 60 days, we may hand you over to a debt collecting agency or a law firm to get the outstanding monies. All costs of the debt collector and/or lawyer will be added to your account.

9. If you have any special circumstances that prevent you from in paying us, please let us know immediately, so that you can make repayment arrangements. Interest will still be charged on these outstanding accounts.

Cancellation of appointments

10. You have to keep your appointments and come to the practice on time. If you have to cancel the appointment, you must inform us 7:00 on the morning of your child's scheduled appointment. If you do not do this, we will still send you an account for the full fee we normally charge. If you are prevented from making the appointment due to an accident or similar emergency, we will not charge you.

About therapy

11. Before we start with therapy:
    11.1. We will talk to you about the options you have and the benefits of each option.
    11.2. We will also tell you if there are any risks (such as risk of hurting yourself or pain) or negative aspects of the therapy.

12. You will then agree to the therapy after the discussions, or you may decide to refuse therapy. If you refuse, we will explain to you what might happen if you do not undergo therapy. Therapy often means more than one session and it may be important that you commit to a series of sessions.

13. Remember that:
    13.1. No therapy can be 100% guaranteed.
    13.2. You always have to follow the instructions and warnings of the therapist carefully.
    13.3. The success of therapy depends on your co-operation and being honest with the therapist.

Initial:_____

13.4. Therapy occurs on an ongoing basis and the success of the therapy is dependent on regular attendance.

13.5. Therapy with a second occupational therapist may result in conflicting therapy goals and can affect the success of your child's therapy, please disclose all other therapies to ensure the best treatment for your child.

14. Discontinuation of therapy may be considered if cancellations occur too frequently and the effectiveness of therapy is hampered. Discontinuation of therapy may also occur, at the therapist's discretion, if an account is in arrears.

15. Should you wish to terminate your child's therapy, a month's written notice is required. If not, you will be charged for the full month.

16. Please be punctual as lost therapy time cannot be made up. Note that children who arrive too early or are collected too late can affect other children's therapy negatively. The therapist is only responsible for your child during therapy time. An additional fee may be charged for child care services should your child not be collected promptly.

17. Parents are welcome to speak to the therapist at the beginning or end of the session. However please make an appointment if a longer discussion is required.

18. Patients should be dressed in comfortable clothes when coming for therapy, so as to allow for the maximal use of equipment.

19. Although the necessary safety precautions are taken, neither the therapist concerned or the establishment can be held responsible for any injury, loss or damages sustained while on these premises.

20. No patient will be permitted in the therapy room without the therapist being present as there is equipment which could be potentially dangerous when used unsupervised.

21. Please refrain from bringing siblings and friends to therapy as this is highly disruptive to your child's therapy and negatively affects the progress.

Confidentiality

22. Every person that gets therapy in this practice has the right to confidentiality (this means to have your personal information kept private, even from family members and employers). Nothing that you share with the Therapist will be passed on to anyone, unless -

22.1. You agree in writing that your information can be shared (e.g. with a school teacher or an employer or anyone other specific person or entity).

22.2. The law on medical aids forces us to provide certain information to the medical aid. When you submit your account to the medical aid, the account includes personal information, such as what your health status is, and the codes (numbers) that indicate the specific therapy you got.

22.3. When we receive an order from a court to disclose your information, we have no choice but to provide it.

22.4. When a specific law makes it compulsory to report things, such as TB, cancer or child abuse or child neglect.

Initial:_____

22.5. Communication with the referring doctor or other healthcare professional, insofar as it is necessary and in the interest of the patient.

23. When anyone else, or any other business (such as an insurance company, your employer, a lawyer) want your information, we will contact you to get your written permission that we can give the information to such person or business.

Parents and children

24. By law, children from the age of 12 can seek healthcare help on their own, if they are able to understand what therapy means. Parents still have to pay for this cost. Unless one of the parents has completed the information above, any one of the child's parents will have to pay the account for the child's therapy. It does not matter if the parents are divorced or not married: any one, or both, may have to pay the account.

25. The above will be explained to children and parents or caregivers. If the child is ok with it, aspects of the proposed therapy and how therapy went will be shared with the parent(s) or caregiver.

RELEASE FORM

In order to provide you and your child with the maximum assistance, it is important that this practice have as much information as possible concerning the developmental history of your child. This includes information related to the difficulties experienced by your child as well as the results of any medical, psychological or any other professional testing.

To obtain reports on such tests and to forward any information (to your doctor, the school, other therapists, other professionals), we require your permission in writing. We assure you that this is purely for your child's best interests and that all information on your family and child will be treated as strictly confidential.

I _____ hereby authorize the release of any information pertaining to (name of child) _____ to the therapist and that the therapist may in turn release similar such information to the school and other such professionals if deemed necessary.

I hereby also declare the information provided is to the best of my knowledge, accurate and true.

NAME _____ in the capacity of parent/guardian

SIGNED _____ DATE _____

INDEMNITY:

I, Mr/Mrs _____ (parent/guardian) hereby give consent for my child _____(child's full name) to participate in Occupational Therapy. I understand that although the necessary precautions for my child's safety and well being will be adhered to at all times, I fully accept that all activities will be undertaken at my child's own risk. I agree to photographs being taken for record keeping purposes. I confirm that I have read, understand and agree to the conditions outlined in this document and have asked all relevant questions which have been answered to my satisfaction. I hereby undertake on behalf of myself, my executors, my spouse and my child to give full indemnity to the therapists working with my child and the establishment in which the receive Occupational Therapy. Full indemnity will include any claim against the therapist or establishment for a loss of any nature or any injury of any nature or severity. I understand and accept the conditions of therapy and indemnity for my child as stated above.

SIGNATURE OF PARENT/GUARDIAN: _____
SIGNATURE OF THERAPIST: _____
DATE: _____

PATIENT DETAILS

Referred by _____

Surname _____

Full names _____

Title _____ ID Number/Date of Birth _____

Postal Address _____ Code: _____

Home Address _____

DETAILS OF THE PERSON RESPONSIBLE FOR THE ACCOUNT

Surname _____

Full name _____

Title _____ ID Number _____

Relationship to patient: ☐ Parent ☐ Grand Parent ☐ Guardian

Postal Address _____ Code: _____

Home Address _____

Telephone/Contact numbers _____

Employer (company name): _____ Employer Tel nr: _____

E-Mail address _____

Signature _____

MEDICAL AID DETAILS

Name of medical aid _____ Plan / Option: _____

Membership no: _____

Main member surname and initials _____

Dependent code of patient _____

RELATIVE AT ANOTHER ADDRESS

Name and surname _____

Relationship to patient / person responsible for account _____

Telephone nr _____

FOR OFFICE USE ONLY

Date of Assessment _____

ICD 10 Codes _____

Type of Assessment _____