Dr Sandra Squara

Registered Homeopath A07476, Certified Functional Medicine Practitioner, IFM
54a 2nd ave Parktown North Tel 0823965346
sandrasquara@vodamail.co.za

PATIENTS INFORMATION

SURNAME _____ Sex M F □

NAME'S _____

Number of Children _____ ID Number: _____

Date of Birth _____ Occupation: _____

Address _____

Contact Number _____

Email Address Home: _____ Work: _____ Cell: _____

_____ You will receive reminders, appointment notifications newsletters

PARENT'S DETAILS IN THE CASE OF THE PATIENT BEING UNDER AGE

SURNAME _____ FIRST NAMES _____

Contact Number: Home: _____ Work: _____ Cell: _____

Email Address: _____

MEDICAL AID DETAILS

Name: _____ Member Number: _____

Main Member: _____

REFERED BY:

Dr Sandra Squara is a registered Doctor of Homoeopathy and is certified in Functional Medicine and Acupuncture.

All invoices including medication must be paid in full after each consultation. If payment is not received for whatever reason, the full amount plus any additional costs incurred in an attempt to receive the outstanding money, will be for the patients account.

Appointments not cancelled within**2**4 hours will be charged for in full. (Courtesy emails reminders are sent, but it remains the patient's responsibility to keep the appointment)

Date: _____ Signature: _____

All information provided is managed in the strictest confidence.

Reasons for this consultation (Please be absolutely specific). When did it start

Specify other Ailments

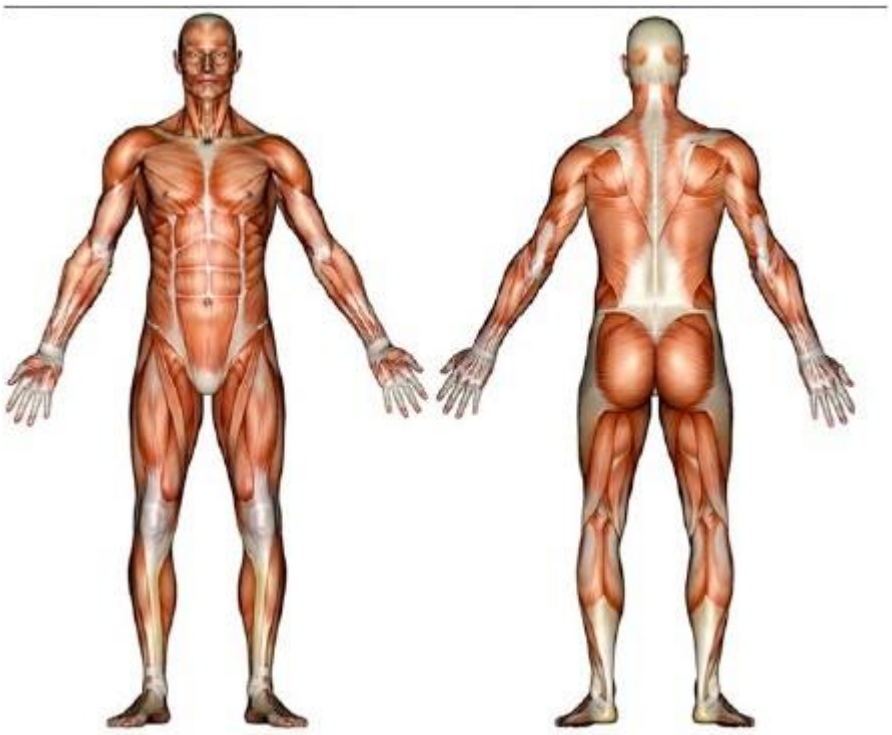
List operations and dates

PLEASE DO NOT DISCONTINUE THE USE OF ANY MEDICATION
UNLESS SPECIFICALLY ADVISED TO DO SO

List ALL medication, vitamins or mineral supplementation including brand, remedies you are taking and the reasons for doing so:

Product	Reason	Duration

Please indicate on the sketch with an X where you are experiencing problems



FEES AND CONDITIONS 2022

Dr Sandra Squara

Consultations

Please ensure that you book the correct appointment type
This is a cash practice

	Fee per Consult
Initial Consult Chronic	R1,250
Initial Consult Acute	R880
*Chronic - You have had this problem for more than 3 months	
* Acute - A more recent condition example cold or flu	
Initial Consult Musculoskeletal and sport injury	R880
Follow up consult	R645
Short appointment 10 minutes (No acupuncture)	R410
Child Initial Consult (Excludes Acupuncture)	R645
Child Follow Up Consult (Excludes Acupuncture)	R450
Telephone / Skype Consult (Non-Claimable) 15 minutes	R510
Detailed Emails to answer	R350
Returning patient (Recomplete new patient intake form if more than 4 years)	
Discussion of DNA tests or Functional Medicine excludes acupuncture	R695

Family Acupuncture sessions

Family session - Book a family Acupuncture appointment	R535

Other treatments Facial rejuvenation acupuncture	R695

Cancellation fees

Appointments must be telephonically cancelled within 24 hours or it will be invoiced in full. Missed appointments will be invoiced in full.

Patient's signature: _____

By signing you accept all fees and conditions described

Consent Form

I hereby give my consent to receive health or related services from the healthcare professional.
Where I am consenting to therapy on behalf of someone other than myself (such as a minor/ incapacitated person), I confirm that I am authorized to give such consent on their behalf as parent/ legal guardian.

Clinical Examinations and Tests

I understand that the primary goal is to help improve my/the patient's physical health/mental health/ wellbeing.
In order to proceed with effective therapy, my/the patient's health/mental health/wellbeing, biological or physiological dysfunction, symptoms, and functional impairment must be evaluated by means of an interview and/or the performance of clinical examinations diagnostic procedures or tests. I hereby consent to such consultations or examinations.
I am aware that anyone of my/the patient's choosing may be present during the consultation or physical examination.
I will notify the healthcare professional of any pre-existing diseases, allergies or mental health/medical conditions which I know of, including pregnancy at the time of seeking or having therapy.
I acknowledge that providing incorrect or misleading information has the potential to be hazardous to my/the patient's health.

Therapy Benefits, Risks and Alternatives

I understand that the healthcare professional treating me/the patient cannot guarantee the outcome or success of the therapy and that the length and duration of the therapy required may differ from person to person.
I understand that the healthcare professional will discuss my/the patient's therapy options with me, the purpose thereof, the benefits and risks (complications or side effects) of same, whether alternative therapies are available and what the benefits and risks (complications or side effects) of those alternatives are, to allow me to come to a decision regarding whether to proceed with the proposed therapy.
I confirm that I have been informed of and understand the healthcare professional's assessment and recommended therapy. If I am not satisfied with the assessment or recommended therapy and do not wish to have the therapy, I will first discuss this with the healthcare professional to work together in discussing my/the patient's physical/mental health status and the management thereof in the absence of such therapy. I intend for this consent to apply to all therapies while I am/the patient is a client of the healthcare professional, however, should it occur that my/the patient's physical/mental health status changes during the course of any therapy, I will be guided by the healthcare professional and actively participate in any decision regarding further management or regime.
Generally the benefits of therapeutic care can outweigh the potential risks however I understand that, as with any healthcare services, there are risks and side effects that may arise during therapies.
Minor side effects may include slight bruising, redness, irritation of skin after dry needling, massage, cupping techniques.
Moderate side effects may include swelling of area needled, slight pain at site of needle which passes within a few hours.
Serious complications may include swelling and pain that may persist after treatment. Aggravation allergy to herbal medication.
I understand that all therapies are performed within a rehabilitative framework and that I/ the patient must follow instructions as given by the healthcare professional.
Should I/ the patient experience any side effects, I confirm that I will immediately notify the healthcare professional. My failure to do so, shall be construed as to mean that I am satisfied with the services provided and that I / the patient have/has not experienced any side effects.

Withdrawal of Consent

I am hereby made aware of my right to withdraw my consent to receive therapy at any time.

Disclosure of Health Records

I understand that health records will include personal information about me and may include a number of things such as medical history, case history, test results, radiology results, audio or visual records such as photographs, videos and tape-recordings; consultation notes, billing records, employment records, referrals, notes from other healthcare professionals, medications (chronic/ non chronic), ICD codes and clinical research and other documents or forms completed during the healthcare interaction.
The ICD-10 (International Statistical Classification of Diseases and Related Health Problems -Tenth Revision) is a diagnostic coding standard owned and maintained by the World Health Organization (WHO) and provides a method of classifying diseases, illnesses injuries and causes of death in a coded format. I consent to the submission of my/the patient's ICD-10 codes to my medical scheme and/or (where required) to the other health professionals (within the health care team) and to these codes being noted or written on any invoice billed by the healthcare professional. I also understand that if I do not want to have my ICD-10 coding divulged to the medical scheme, this could mean my medical scheme may not honour the claim and I would have to settle the healthcare professional's account directly.
I also understand that once my healthcare professional has disclosed the ICD-10 codes to the medical scheme, he/she does

not have control over the management and utilization of this information and the medical scheme takes responsibility for any further disclosure or utilization of such information for whatever purpose.

I consent to my/the patient's healthcare information being shared with/for:
Other healthcare professionals involved in management of my/ the patient's therapy Y/ N
Legal matter as part of any legal issue between the patient and healthcare professional Y /N
Employer/potential employer employment related matter Y/N
Family/ family member/ partner Y/N
Research Y/N
Teaching/training provided I/the patient remain/s anonymous Y/N
Other (please specify)

Confidentiality

I am aware that patients and healthcare professionals have rights and responsibilities in terms of the National Patients' Rights Charter and the Constitution of South Africa.
I am aware of the risks involved in the sharing of information via social media, even if the consequences are unintended. I confirm that I will respect the healthcare professional and other patients by not using social media as a platform to make any speculations about the healthcare professional or the healthcare services rendered by him/her.

Protection of Personal Information

The healthcare professional uses and appoints practice management as its operators of patient data to support its workflow. I/the patient hereby give consent for these operators appointed or such other operators as may be instructed, to process my/ the patient's personal information and/or process claims my medical scheme on my/ the patient's behalf, to provide e-scripts, and to host telehealth consultations within their scope of providing support to the healthcare professional. The aforementioned operators appointed by the healthcare professional will not transmit my/ the patient's personal information outside the borders of South Africa or retain it for any other purposes, other than to effect its duties.
I understand my/ the patient's right to privacy and to have my/ the patient's communications with the healthcare professional protected.
The healthcare professional will do his/her best to ensure that he/she complies with the legal requirements of the POPI Act No. 4 of 2013 ("POPIA") which regulates the manner in which he/she collects, processes, uses, stores, shares and destroys my/the patient's healthcare records ("personal information") which I have provided to him/ her.
The healthcare professional will collect my/ the patient's personal information primarily to supply me/ the patient with healthcare services but also to liaise with me telephonically and respond to any query or comment received from me.
The healthcare professional will process my/ the patient's personal information for purposes of evaluating, diagnosing and treating me which I have specifically engaged him/her to do.
The healthcare professional will treat my/ the patient's personal information as strictly confidential in line with legislation and Ethical Rules governing his/her profession.
Records will be stored by the healthcare professional for a period of 6 (six) years after they become dormant or such other legislated time period applicable to the retention of records.
In certain circumstances, where special reasons exist, the healthcare professional may seek my consent to store my/ the patient's records for a time period exceeding the prescribed statutory time periods.
The healthcare professional will take appropriate technical and organizational measures to ensure that my/ the patient's personal information is kept secure and is protected against unauthorized or unlawful processing, accidental loss, destruction or damage, alteration, disclosure or access.
The healthcare professional will promptly notify me if he/she becomes aware of any unauthorized use, disclosure or processing of my/ the patient's personal information.
I understand that although the healthcare professional will take the aforementioned precautions in protecting my/the patient's personal information, he/she shall not be liable for any loss or damage, howsoever arising, suffered as a result of the disclosure of such information if outside of his /her reasonable control.

I acknowledge that I have the right to:
a. Rectify my/the patient's personal information collected by the healthcare professional if it is inaccurate, dated or misleading;
b. Object to the processing of my/the patient's personal information (subject to legislation);
c. Request the return or destruction of personal information (subject to legislation);
d. Lodge a complaint with the healthcare professional;
e. Lodge a complaint with the Information Regulator, whose details are Tel: 012 406 4818/ Email: inforeg@justice.gov.za.

Access to Information
I understand my/ the patient's right to access health records that are required for the exercise or protection of any rights. Records should be requested in writing and in the prescribed format. Fees for the reproduction of files may be applicable.

Informed Consent to the Financial Responsibility for Account
I confirm that I have supplied all personal details to the healthcare professional for purposes of addressing and billing me/the medical scheme or main member correctly.
I have been informed of the costs of the therapy before the commencement. I will also be entitled to a fee breakdown even if the fees are paid by my medical scheme. Where I have no medical aid, the fees are due and payable immediately on completion of the healthcare services. Where I have medical aid, I understand that I/ the main member might not be fully reimbursed by the medical scheme and that I am/the main member, will be responsible for claiming a refund from the medical scheme. Should I fail to cancel an appointment 24hrs ahead of the scheduled therapy, I may be invoiced for the missed consultation. Should I/the main member not effect payment of any outstanding invoice, the healthcare professional will proceed as follows:
1. Within 30 days, make a follow up call, send an SMS or Email to the personal contact details provided on the patient intake or this form;
2. After 30 days send an overdue notice to the physical or email address appearing on the on the patient intake or this form;
3. Thereafter hand over the account to attorneys for collection.
I acknowledge that as a result of my/ the member's failure to pay the account, I/ the member will be liable for all legal fees, on an attorney and own client scale as well as collection commission and tracing fees, incurred in the collection of the outstanding amount.

☐ **Marketing** (tick the relevant clause)
I wish to receive information about health topics, products, services and offers that may interest me. I agree that the healthcare professional may contact me using the contact details provided by me on the patient intake or this form.

☐ I do not wish to receive information about products, services and offers that may interest me.

Declaration
By signing this form, I am legally bound by the provisions of this contract.
Patient/Parent/Legal Guardian [delete whichever is not applicable]:
Name: _____

Signature: _____Date_____

Person Responsible for the Account if not the same person as above.
Name: _____

Signature: _____Date_____

Withdrawal of Consent
I hereby withdraw my consent for the undermentioned therapy for me/the patient it has been explained to me, that by discontinuing the therapy, there might be implications, risks and obligations for my/the patient's physical/mental health. Such implications, risks and obligations have been explained to me. I have considered these implications, risks and obligations and herewith confirm my decision to discontinue.

Patient/Parent/Guardian/Curator [delete whichever is not applicable]:
Name: _____

Signature: _____Date_____

Timeline of your diseases,significant events in your life

Please complete in chronological date order any conditions that you have had in your life. Think about surgeries, doctor visits, hospital visits, emotional trauma and stress. Anything that had an impact on your life. Even if you never have been well since a cold / flu etc. Approximate time is suitable Oct 2009 or just the year if you are not sure

HEALTH QUESTIONAIRE

Patient Name:_____ **Date:** _____

Rate each of the following symptoms based on your typical health profile for the specified duration:

☐ Past month (New Patient) Past week (Follow-Up) ☐ Past 48 hours (Acute) ☐

If you are a new patient then complete the questionnaire with the past month duration – **PLEASE ADD SCORES WHEN COMPLETE**

Point Scale: 0 – *Never or almost never* have the symptom. **1** – *Occasionally* have it, effect in *not severe.* **2** – *Occasionally* have it, effect is *Severe.* **3** – *Frequently* have it, effect is *not severe* **4** – *Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD_____Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia **TOTAL**_____

EYES _____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision **TOTAL** _____

EARS _____ Itchy Ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
TOTAL _____

NOSE _____ Stuffy Nose
_____ Sinus problems
_____ Hay Fever
_____ Sneezing attacks
_____ Excessive mucus formation
TOTAL _____

MOUTH/_____Chronic coughing
THROAT
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of invoice
_____ Swollen or discolored tongue, gums, lips
_____ Canker Sores **TOTAL** _____

DIGESTIVE_____Nausea, vomiting
TRACK
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
TOTAL _____

JOINTS/ _____ Pains or aches in joints
MUSCLE
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Feeling of weakness or tiredness
_____ Pains or aches in muscles
TOTAL _____

WEIGHT _____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Water retention
_____ Underweight
_____ Compulsive eating
TOTAL _____

ENERGY/ _____ Fatigue, sluggishness
ACTIVITY
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **TOTAL** _____

SKIN_____Acne

_____ Hives, rashes, dry skin

_____ Hair Loss

_____ Flushing, hot flashes

_____ Excessive sweating **TOTAL** _____

HEART_____Chest Pain

_____ Irregular or skipped heart beat

_____ Rapid or pounding heartbeat

TOTAL _____

LUNGS_____Chest congestion

_____ Asthma, bronchitis

_____ Shortness of breath

_____ Difficulty breathing **TOTAL** _____

MIND_____Poor Memory

_____ Confusion, poor concentration

_____ Difficulty in making decisions

_____ Stuttering or stammering

_____ Slurred speech

_____ Learning disabilities

_____ Poor concentration

_____ Poor physical coordination

TOTAL _____

EMOTIONS_____Mood swings

_____ Anxiety, fear, nervousness

_____ Anger, irritability, aggressiveness

_____ Depression **TOTAL** _____

OTHER_____Frequent illness

_____ Frequent or urgent urination

_____ Genital itch or discharge

TOTAL _____

GRAND TOTAL **TOTAL** _____

Please add up scores for each section when do