



NISHA PILLAY
Occupational Therapy
BSc(OT) WITS

Sensory Intelligence Practitioner; NDT and F.C.E trained

PR. No. 0490652

THERAPY CONTRACT: TERMS AND CONDITIONS

2022

Being a client at this practice signifies that you, (the client or legal guardians of the client) are subject to comply with the following, during the period of intervention:

About the therapy:

1. Before starting therapy:

- a. The therapy options will be discussed, including the benefits of each
- b. You will be informed of any risks involved (hurting yourself and pain) or negative aspects of therapy
- c. Disadvantages of not undergoing therapy and being compliant will also be discussed

2. After the discussion, you will have to decide whether to agree to or refuse therapy.

3. NB! Please remember:

- a. Therapy is never 100% guaranteed
- b. Warnings and instructions of the therapist always needs to be followed carefully
- c. Success of therapy depends on your co-operation and honesty with the therapist
- d. Therapy occurs on an ongoing basis and the success of therapy is also influenced by regular attendance and regular practice at home.

4. Termination of therapy will be considered by the therapist if cancellations occur too frequently, and the effectiveness of therapy is hampered.

5. Therapy will also be discontinued when a client is discharged from the therapist's services.

6. Should YOU wish to terminate therapy, please inform the therapist telephonically or in written form via email, or physical letter.

7. Please be punctual and prepared – therapy time lost cannot be made up. Arriving too early and leaving late, hampers other client's therapy. The therapist is only responsible for one client for the duration of their booked appointment. You will still be charged for a full session.

8. Parents and family or clients are welcome to talk to the therapist at the beginning or end of the session, however should it require more than 5minutes, you will be encouraged to book an additional session. If time is available for the therapist after the session discussions are welcome however, you will be billed for an additional 15 minutes.

9. Clients must be dressed in comfortable clothes, so that no movement is restricted. If the client is attending

sessions requiring them to do exercise, it is requested that no skirts or dresses must be worn.

10. In all sessions, all necessary safety precautions will be taken, however, the therapist will not be held responsible for any injury, loss or damages sustained on the premises.

11. No client is permitted to use equipment in the absence of the instruction of the therapist, as some of the equipment may be potentially dangerous, when used unsupervised.

12. Please also refrain from bringing friends and family members that will distract the client or prevent the client from engaging in the therapy session optimally.

13. A parent/caregiver/spouse is requested to attend sessions, where the client is reluctant to follow a home programme, to ensure effective carryover.

Confidentiality / (POPIA – short)

1. Every client receiving therapy at this practice has a right to confidentiality. This means that the client's personal information, will be kept private from family members, other health professionals and employers/ teachers – unless:

a. The client signs a written agreement to allow the information to be disclosed to a 3rd party, mentioned in the agreement and an agreement to confidentiality is signed by the 3rd party to keep the client's information confidential.

b. The law on medical aids forces the practice to provide certain information to the medical aid. When clients submit their accounts to the medical, the accounts include personal information, such as the client's health status, and codes indicating the specific therapy received and diagnosis ICD codes.

c. If an order from court is received to disclose client information, the practice is ethically bound to providing it.

d. A specific law enforces compulsory report of conditions such as TB, cancer, abuse and neglect; or circumstance causing harm to the client or of the client being at risk of harming his/herself or others.

e. Communication with the referring doctor or other health care professional/ educator is necessary and done within the best interest of the client in a confidential manner.

2. Should anyone else contact the practice, requesting client information, the client will be contacted, and the client will have to provide written consent for the practice to disclose any information regarding the client.

3. To maintain a high level of confidentiality reports of any nature will not be emailed or faxed or otherwise sent (whatsapp/messenger). Hard copies will be available at feedback sessions for all children and adult clients who request reports.

4. This practice uses email, Facebook messenger, Sms and Whatsapp business as modes of communication, no personal information or demographics will be requested by the therapist or shall be sent by the client over these. Personal messages that you consider confidential MUST NOT be sent via these channels to the therapist. Should you want to inform the therapist of progress, or any information that is considered confidential to the client it should be done when the therapist is available to answer a phone call in a secluded area (ask the therapist to call back at a suitable time) or an appointment must be made to discuss the matter.

a. Should you send personal information regarding a client that is considered confidential, the therapist will remind you, of the way you should communicate this information, in the response to your message.

Should any practice management strategies change in future that affects the confidentiality of your information. You will be informed and requested to sign a new contract with the practice.

Office hours:

By appointment only

*** Please note that the therapist does not work out of set hours unless she has made special provision to do so.

The therapist will not answer client calls after 17:00. Whatsapp messages are welcome but please do not expect a prompt response as the therapist can only tend to messages between clients and in allocated administrative time.

After hour WhatsApp messages to make appointments are welcome. However the therapist is not obligated to respond after hours.

Payment information

1. The therapist will quote you prior to your session for assessments.
2. The client is then **expected to pay via eft/ card/ cash at the end of each session.**
3. Invoices and receipts will be printed/emailed to you after the payment has been received.
4. If the client is unable to make the payment on the day, please inform the therapist as soon as possible so alternative repayment methods can be arranged. If the therapist is not informed, the client will be charge 1.5 % interest per month, calculated from the date of the first rendered amount.

***If you do not pay within 90 days. Contracts will be terminated and the client will be handed over to a debt collector to retrieve all outstanding monies. All costs of the debt collectors will be added to your account.

It is regretted that **no cheques are accepted.**

Banking Details

Bank: ABSA

Acc no.: 4096806727

Branch code: 632005

Type: business current

Always use your file number issued by the therapist.

Medical aids/ medical aid schemes

1. This is a cash-based practice with private rates.
2. This practice is NOT contracted to medical aids. Because of this, the practice DOES NOT submit the account on your behalf. It is your responsibility to settle the account directly with the therapist, and then claim back from the medical aid/scheme.
3. Medical aids may occasionally pay less than what the practice charges or sometimes they do not pay at all. Please note: You will still have to pay the full account. Where applicable the client may request a report to assist a PMB form, however there is a fee accompanying this request that will be billed and should be claimed back from your medical aid.
4. Assessment and report fees differ in terms of the condition and dysfunction as well as complexity of the case.
5. Reports can be requested by any of the following: referring doctor/specialist, allied professional, employer, insurance company, patient/client, parent/family or school. The cost of this report is NOT included in the assessment codes' reimbursement and is billed/coded separately. This means that MEDICAL AIDS DO NOT PAY FOR REPORTS, and the CLIENT IS LIABLE FOR THE COST thereof. In the case of an employer or insurance company requesting a functional report, the insurance company or employer should be responsible for reimbursing the client unless special arrangements have been made between insurer and this practice. Please make sure a referral letter is available for clarity.
6. At times a client may require additional programmes, home visits, work visits or school visits, to aid the therapy process, the clients' progress and return to work goals. These may be suggested by the therapist with a quotation or a quotation for these requested by the client/ client's family/employer/insurance. This value is an estimated value and is subject to change and does include travel costs of the therapist according to the AA rates. If you are uncertain of quotations and fees, please feel free to ask.

6. The cost of specific materials used during therapy may differ and you will therefore be informed of the cost, if it is not already included in the session fee.

Cancellation of appointments /Appointments missed

1. Should you need to CANCEL a session, it should be done AT LEAST 24 HOURS PRIOR to the session telephonically or via sms/whatsapp/email if telephone is not answered.

2. If you miss an appointment, you will be charged for the session. (Please note that medical aids do not cover cost of appointments missed) FIRST SESSIONS AND ASSESSMENT SESSIONS WILL BE CHARGED FOR AT THE SAME RATE AS A 30 MINUTE CONSULTATION. MISSED TREATMENT SESSIONS WILL BE CHARGED IN FULL FOR THE SESSION TIME FRAME AGREED UPON.

3. Should an appointment be missed due to an emergency situation, or you are sick on the day, you will be expected to provide evidence of this to dismiss the charge for the missed appointment.

Thank you for taking the time to read through the contract.

Please sign below if you agree with the terms and conditions.

Name of client

Name of parent/legal guardian/spouse

Thumb print/signature of client

Signature of parent/legal guardian