



DR. SANDRA SQUARA

Maximum results will be gained if patients follow the protocols, diets, supplementation and treatment (including frequency) prescribed.

PATIENTS INFORMATION
SURNAME
FIRST NAME(S)
Number of Children
Date of Birth
Physical Address
Postal Address
Contact Number: Home: Work: Cell:
Email Address: - you will receive reminders, appointment notifications and practice newsletters via email

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:
Main Member:
Member Number:

REFERRED BY:

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 24 hours will be charged for in full. (Courtesy emails reminders are sent, but it remains the patients responsibility to keep the appointment)

Date:

Signature:

P.T.O

All information provided is managed in the strictest confidence.

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

Specify other Ailments

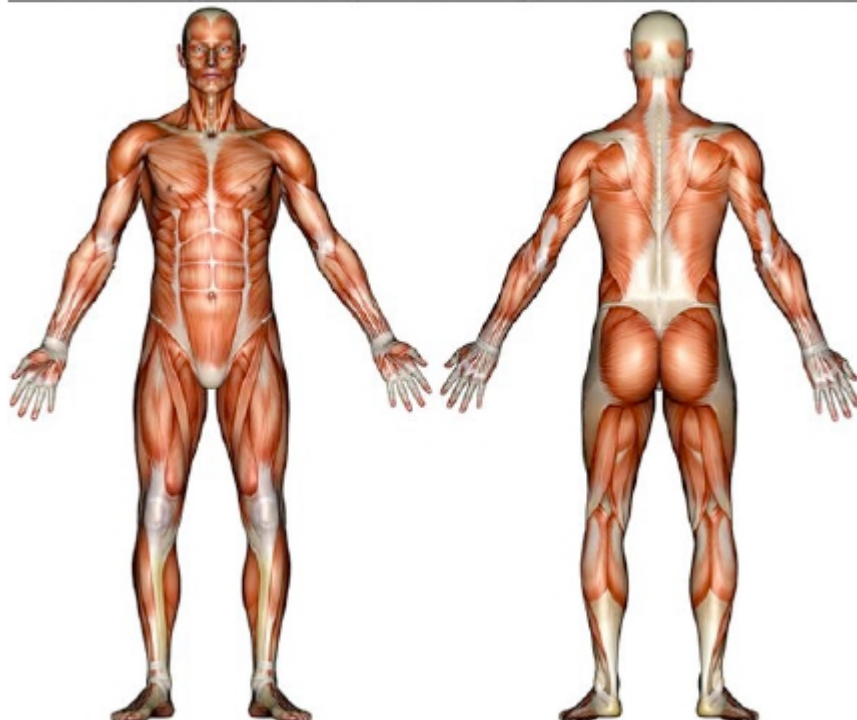
List operations and dates

**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 2018

Dr Debbie Smith and Dr Sandra Squara

Consultations

* New Patients

- Please ensure that you book the correct appointment type.
- Point of Origin will invoice patients according to the service provided if booked incorrectly

* Existing Patients

- Please inform Reception of the correct appointment type otherwise a standard follow up appointment (R620) will be invoiced

NEW PATIENTS		Fee per Consult
1	Initial Consult: Chronic * (Patients that have not visited the practice for 2 years or more will be considered new) See Menu 3 for muscle treatments	R950
	*Chronic - You have had this problem for more than 3 months	
2	Initial Consult: Acute **	R730
	** Acute - A more recent condition example cold or flu, diarrhoea	
3	Initial Consult: Musculoskeletal / Sport Injury	R730
EXISTING PATIENTS		
4	Returning patient with chronic condition (If no consultation for 2 years then please book initial consultation - complete all new documentation if chronic)	R950
5	Follow up consult (all conditions)	R620
6	Short appointment 15 minutes (No acupuncture)	R365
CHILDREN		
7	Child Initial Consult (Younger than 10 yrs and no Acupuncture)	R620
8	Child Follow Up Consult (Excludes acupuncture)	R365
TELEMEDICINE		
9	Telephone / Skype Consult (Non-Claimable)	R450
10	Emails that take 10 minutes to answer	R350

Enquire about our multiple appointments

Rates below do not include medication

Family Acupuncture sessions

11	Family session - Book an Acupuncture appointment at the same time with a family member or friend and enjoy a family rate	R456 each
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Other treatments - Choose separate on online booking system

12	Lymphatic drainage (Please bring skipants or tight exercise clothing) 45min	R240
13	Sports recovery compression treatment (Please bring tight exercise clothing) 45min	R240
14	Foot soaks (Time dependant on condition being treated) Dress appropriately for legs below knee will be exposed 30 - 45min	R360
15	Facial rejuvenation acupuncture - Includes a pretreatment gel and post treatment serum to enhance collagen and reduce fine lines)	R620
16	Bioptron Light - for treating inflammation, skin problems, scars, acne, joint problems, sprains, arthritis, sinus probles. (Included in acupuncture treatments if needed without an additional charge)	R250

Cancellation fees

Missed appointments or appointments not cancelled within 24 hours will be invoiced in full.

All fees are inclusive of 14% VAT

Patients signature: _____

By signing you accept all fees and conditions described

INFORMED CONSENT AND TERMS AND CONDITIONS

This constitutes a legally binding agreement between Dr Sandra Squara
(Registration no: A7476)

And
Name _____ ID Nr: _____

This agreement is made of two parts.

Number 1 – Informed consent

Number 2 – Terms and Conditions of your treatment

By fixing your signature hereto you confirm that you have understood and agreed to these terms and conditions.

INFORMED CONSENT

1. I the undersigned acknowledge and understand that I have a legal duty to fully inform Dr Sandra Squara of any and all relevant medical information, which may be pertinent to my consultation with her. This shall include (but not be limited to) information pertaining to any diagnosis, current treatment, or medical condition of which I am aware, or am currently receiving treatment or care for by a registered health care professional.
2. I confirm that the purpose and nature of therapy and or advice, together with the benefits, risks, if any, associated with such advice have been fully explained to me, and that I have been afforded the opportunity to ask any questions pertaining to such.
3. I further confirm that I am responsible for the manner in which I utilise the information given to me, and that where necessary I shall consult with my treating health care professional as and when advised to do so.
4. Dry needling consent. Acupuncture means the stimulation of certain points near the surface of the body by the insertion of special needles. Dr Squara uses the Dry needling technique. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalisation of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. The potential risks: slight pain or discomfort at the site of the needle insertion, infection, bruising, weakness, fainting, nausea and aggravation of problematic systems existing prior to acupuncture treatment. The potential benefits: Acupuncture may allow for the painless relief of one's symptoms without the need for drugs, and improve balance of the body leading to prevention of illness, or the elimination of the presenting problem.

Signature: _____ Date: _____

2. TERMS AND CONDITIONS

- 2.1. I understand that in accordance with section 14 of the National Health Act, 2003, I have the right to medical privacy and confidentiality, and that such information may not be disclosed to any party without my written authorisation.
- 2.2. In accordance with paragraph 2.1 above, I hereby provide written authorisation to Dr Sandra Squara to disclose any information to my treating health care practitioner, medical scheme or insurer (where applicable), which shall include any information pertaining to my consultation, nutritional advice and related matters.

3. PAYMENT OF FEES

- 3.1. I acknowledge that notwithstanding any membership of any medical scheme, I am personally responsible for the payment of any and all amounts due to Dr Sandra Squara for her services rendered. This is a cash practice. All consultations and medications need to be settled in full after each consultation. Repeat medications need to be settled in full at time of collection and dispensing them. Any special medication that is prepared or ordered at the time of preparing the medication or ordering them will be for my account. Furthermore, in the event that I claim from my medical scheme or insurer, and for whatever reason either fails to pay, or pays only in part, I shall be responsible for any amount still owing to Dr Sandra Squara or part thereof, in my personal capacity.
- 3.2. I understand that it is my sole responsibility to submit claims to my medical scheme or insurer, and that Dr Sandra assumes no responsibility in this regard.
- 3.3. I confirm that I have had all the costs associated with Dr Sandra Squara's services explained to me, and that I have agreed to those charges.
- 3.4. In the event that I fail to pay any amount to Dr Sandra Squara, and costs are incurred in the recovery thereof, I shall be liable for those costs, including (but not limited to) any legal fees (at attorney and client scale), tracing fees and other related costs associated therewith.
- 3.5. Missed or cancelled appointments not notified to the practice 24 hours in advance will be invoiced in full.

4. DISCLAIMER

- 4.1. I confirm that Dr Sandra Squara makes no claim to cure or treat any specific medical condition by the advice or treatment she provides.

5. WARRANTY

- 5.1. I hereby warrant that prior to beginning any health program I will consult with my treating practitioner, and where necessary, ensure that he or she is informed at all times.
- 5.2. In the event that I sign this Agreement on behalf of any minor, I warrant that I am authorised to act on his or her behalf, and that I am legally entitled to make informed decisions pertaining to his or her health.

Initial _____

6. GENERAL

6.1. Appointment times: In order to fully benefit from your treatment, please arrive at least a few minutes prior to your appointment time. In the case that you are late, your treatment will be shortened so that we may keep on schedule for our subsequent patient.

6.2. Blood test results: Where appropriate Dr Squara will email or SMS results if interpreted to be normal. Out of range pathology and all specialised Functional Medicine tests including DNA reports will require a follow up appointment to be scheduled.

6.3. Medicines or supplements specially compounded or specially ordered for a patient will require payments to be made before such items are compounded or ordered by the practice. These items are not refundable regardless of whether they have been collected by the patient.

6.4. Dispensed medicines may not be returned.

By signing this document you legally bind yourself to the terms and conditions contained herein.

Thank you for your understanding and cooperation.

Signature: _____ Date: _____

HEALTH QUESTIONNAIRE

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 is *not severe*.
 Severe. 3 - *Frequently* have it, effect is *not severe*

2 - *occasionally* have it, effect is

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 voice
 _____ Swollen or discoloured tongue, gums, lips
 _____ Canker Sores **TOTAL** _____

DIGESTIVE _____ Nausea, vomiting
TRACK _____ Diarrhea
 _____ Constipation
 _____ Bloating 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** _____

<p>SKIN _____ Acne _____ Hives, rashes, dry skin _____ Hair Loss _____ Flushing, hot flashes _____ Excessive sweating TOTAL _____</p> <hr/> <p>HEART _____ Chest Pain _____ Irregular or skipped heart beat _____ Rapid or pounding heartbeat <div style="text-align: right;">TOTAL _____</div></p> <hr/> <p>LUNGS _____ Chest congestion _____ Asthma, bronchitis _____ Shortness of breath _____ Difficulty breathing TOTAL _____</p> <hr/>	<p>MIND _____ Poor Memory _____ Confusion, poor concentration _____ Difficulty in making decisions _____ Stuttering or stammering _____ Slurred speech _____ Learning disabilities _____ Poor concentration _____ Poor physical coordination <div style="text-align: right;">TOTAL _____</div></p> <hr/> <p>EMOTIONS _____ Mood swings _____ Anxiety, fear, nervousness _____ Anger, irritability, aggressiveness _____ Depression TOTAL _____</p> <hr/> <p>OTHER _____ Frequent illness _____ Frequent or urgent urination _____ Genital itch or discharge <div style="text-align: right;">TOTAL _____</div></p> <hr/> <p>GRAND TOTAL TOTAL _____</p> <hr/>
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Please add up scores for each section when done.

Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

Medical (Men)

- Benign prostatic hyperplasia (BPH)
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other _____
- Age of first period _____
- Date of last gynecological exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-section _____
- Surgical menopause
- Menopause
- Date of last menstrual cycle _____
- Length of cycle _____ days
- Interval of time between cycles _____ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other _____

Health Habits

- Tobacco:
Cigarettes: #/day _____
Cigars: #/day _____
- Alcohol:
Wine: #glasses/d or wk _____
Liquor: #ounces/d or wk _____
Beer: #glasses/d or wk _____
- Caffeine:
Coffee: cups/d _____
Tea: cups/d _____
Soda w/caffeine: #cans/d _____
Other sources _____
- Water: #glasses/d _____

Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk
- Run, jog, jump rope
- Weight lift
- Swim
- Box
- Yoga

Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
 dairy wheat eggs
 soy corn all gluten
- Other _____

Food Frequency

- Servings per day:
Fruits (citrus, melons, etc.) _____
Dark green or deep yellow/orange vegetables _____
Grains (unprocessed) _____
Beans, peas, legumes _____
Dairy, eggs _____
Meat, poultry, fish _____

Eating Habits

- Skip breakfast
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source _____
- Magnesium
- Zinc
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs - teas
- Herbs - extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other _____

Would you like to:

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be less depressed
- Be less indecisive
- Feel more motivated
- Be more organized
- Think more clearly and be more focused
- Improve memory
- Do better on tests in school
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds and flus
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)