



# POINT OF ORIGIN

DR. SANDRA SQUARA

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

## PATIENTS INFORMATION

SURNAME \_\_\_\_\_ Sex M  F

FIRST NAME(S) \_\_\_\_\_

Number of Children \_\_\_\_\_ ID Number: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Occupation: \_\_\_\_\_

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: \_\_\_\_\_ Member Number: \_\_\_\_\_

Main Member: \_\_\_\_\_

## 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 2020

### Dr Debbie Smith and Dr Sandra Squara

#### Consultations

##### \* New Patients

- Please ensure that you book the correct appointment type.
- Point of Origin will bill patients according to the service provided regardless of the the service selected if incorrect

##### \* Existing Patients

This is a cash practice

*INFORMED CONSENT, TERMS AND CONDITIONS, BILLING, PRIVACY POLICY AND DISCLAIMER*

<https://drdebbie.co.za/about/billing-policy/>

|  | Fee per Consult |
|--|-----------------|
| 1 Initial Consult Chronic * See Menu 3 for muscle treatments   | R1,255          |
| 2 Initial Consult Acute *  | R880            |
| *Chronic - You have had this problem for more than 3 months  |                 |
| * Acute - A more recent condition example cold or flu, diarrhoea   |                 |
| 3 Initial Consult Musculoskeletal and sport injury (New appointments)  | R880            |
| 4 Follow up consult  | R745            |
| 5 Short appointment 10 minutes (No acupuncture)  | R410            |
| 6 Child Initial Consult (Excluded Acupuncture)   | R760            |
| 7 Child Follow Up Consult (Excludes Acupuncture)   | R450            |
| 8 Telephone / Skype Consult (Non-Claimable) 15 minutes   | R510            |
| 9 Detailed Emails to answer  | R350            |
| FAQ regarding emails : <a href="https://tinyurl.com/y9bxggul">https://tinyurl.com/y9bxggul</a>   |                 |
| Returning patient (Recomplete new patient intake documentation. (Patients that have not visited the practice for 4 years or more will be considered new if there is a new reason for consultation) |                 |
| 10 Discussion of DNA tests or Functional Medicine tests - Excludes acupuncture. If you need an acupuncture session please book a separate appointment.   | R695            |

Enquire about our multiple appointments rate

Rates below do not include medication

#### Family Acupuncture sessions

|   |           |
|---|-----------|
| 11 Family session - Book an Acupuncture appointment at the same time with an existing family member or friend patient and enjoy a family rate | R535 each |
|---|-----------|

#### Other treatments - Choose separate on online booking system

|   |      |
|---|------|
| Lymphatic drainage (Please bring tights) 45min  | R290 |
| Sports recovery compression treatment (Please bring tights / shorts) 45min  | R290 |
| Foot soaks (Time dependant on condition being treated) Dress appropriately for legs below knee will be exposed 30 - 45min   | R360 |
| Facial rejuvenation acupuncture - Includes a pretreatment gel and post treatment serum to enhance collagen and reduce fine lines)   | R695 |
| Bioptron Light - for treating inflammation, skin problems, scars, acne, joint problems, sprains, arthritis, sinus problems. (Included in acupuncture treatments if needed without an additional charge) | R270 |

#### Cancellation fees

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

All fees are inclusive of 15% 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*. 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 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><b>SKIN</b> _____ Acne<br/>           _____ Hives, rashes, dry skin<br/>           _____ Hair Loss<br/>           _____ Flushing, hot flashes<br/>           _____ Excessive sweating <b>TOTAL</b> _____</p> | <p><b>MIND</b> _____ Poor Memory<br/>           _____ Confusion, poor concentration<br/>           _____ Difficulty in making decisions<br/>           _____ Stuttering or stammering<br/>           _____ Slurred speech<br/>           _____ Learning disabilities<br/>           _____ Poor concentration<br/>           _____ Poor physical coordination<br/> <b>TOTAL</b> _____</p> |
| <p><b>HEART</b> _____ Chest Pain<br/>           _____ Irregular or skipped heart beat<br/>           _____ Rapid or pounding heartbeat<br/> <b>TOTAL</b> _____</p>  | <p><b>EMOTIONS</b> _____ Mood swings<br/>           _____ Anxiety, fear, nervousness<br/>           _____ Anger, irritability, aggressiveness<br/>           _____ Depression <b>TOTAL</b> _____</p>   |
| <p><b>LUNGS</b> _____ Chest congestion<br/>           _____ Asthma, bronchitis<br/>           _____ Shortness of breath<br/>           _____ Difficulty breathing <b>TOTAL</b> _____</p>                        | <p><b>OTHER</b> _____ Frequent illness<br/>           _____ Frequent or urgent urination<br/>           _____ Genital itch or discharge<br/> <b>TOTAL</b> _____</p>  |
| <p><b>GRAND TOTAL</b> _____</p>   | <p><b>TOTAL</b> _____</p>  |

**Please add up scores for each section when done.**

Grandpa



Dad

Grandma



Mom

Grandpa



Grandma



Brother / Sister

Brother / Sister

Brother / Sister

Brother / Sister

- Add any condition that t your family might have  
(If you are unsure please make that ntoe)