

CLIENT INFORMATION

CLIENT		
Surname:		
Name:		
ID number / Date of birth:		
Postal address:		
Code:		
Residential address:		
Code:		
Tel. No. (Cell):	(W):	(H):
Home language:	School:	Grade:
Marital status of parents in case of the client being a minor:		
PERSON RESPONSIBLE FOR ACCOUNT		
Surname:		
Name:		
ID number:		
Occupation:	Employer:	
Work address:		
		Code:
Residential address:		
		Code:
E-mail address:		
Tel. No. (Cell):	(W):	(H):
Medical aid:	Medical aid number:	
Dependant code of client:	Medical aid option plan:	
Name, contact number and relationship of family member / friend not living at the same address:		
Name:	Tel:	Relationship:
GENERAL PRACTICIONER		
Initials and surname:		
Tel. No:		
PREVIOUS MENTAL HEALTH CONSULTATIONS		
Practitioner:	Date:	
Practitioner:	Date:	

PROFESSIONAL AGREEMENT

Reports: In terms of the ethical code, with reference to forensic activities and/or reports, this psychologist does not provide forensic reports.

1. CONSENT TO ASSESSMENT AND THERAPY

I the undersigned, hereby give my consent to the psychologist of this practice to:

- To interview myself / the client and perform an assessment.
- To gather / give information from / to relevant parties as agreed, provided that it is done in the interest of myself / the client / a family member / or other relevant parties.
- That the information gathered throughout our interaction could be used anonymously and confidentially for research, training or supervision purposes.

2. CONFIDENTIALITY

The Ethical Code requires the psychologist of this practice to treat all information as confidential, except in the following circumstances:

- Where there is a risk that the client and/or another person's life is in danger;
- Where the client gave his/her consent that the information may be shared;
- Where a court of law / or a legal statute requires the psychologist to disclose the information,
- Medical aids require a therapeutic code for payment of your invoice.

3. TERMINATION OF THERAPY

The client or the psychologist may terminate the therapy at any stage. Should the psychologist terminate the therapy, it will be done in a professional manner, in consultation with the client.

4. ADDITIONAL INFORMATION

The client is encouraged to ask questions during the sessions if anything is not clear to him / her.

5. ENTERING OF SITE AT YOUR OWN RISK

The client enters the premises and consulting room at own risk. The psychologist does not accept and responsibility for any loss and / or injury of any kind that may be sustained on the premises.

6. PERMISSION TO ASSESSMENT OR THERAPY OF CHILDREN

Both parents must give permission to the assessment or therapy. It is the responsibility of the parent(s) to inform the psychologist if they are divorced.

7. PERMISSION TO DISTRIBUTE PSYCHOLOGICAL REPORTS

I hereby give permission to the psychologist to distribute the psychological report to relevant others **if requested**. Please tick:

- Client's school (relevant teachers)
- In the case of divorced parents to the relevant other
- Other professionals (e.g Occupational therapist, speech therapist, remedial therapist etc.)

8. FEES

I, the undersigned, take note of and agree to the following:

- This practice is run on a cash basis or claiming from my medical aid, if funds are available. Cash fees are charged in line with those prescribed by the "Board of Healthcare Funders" (BHF).
- Assessment and/or therapy fees can be quoted on and sent to me by e-mail before the session, if I am a cash client.
- An invoice will be sent to me after the session.
- I agree to settle the full amount of the therapy / assessment on the day on which it took place if I prefer the cash option or if my medical aid does not cover my session.
- The fact that the invoice states a Practice number and BHF codes (as required by medical aids) does not guarantee that my medical aid will pay the account.
- Accounts are only settled by EFT (electronic funds transfer).
- A full consultation fee will be payable if I do not cancel my appointment at least 24 hours before the time, or if I do not show up for a scheduled appointment.
- I will not use the psychological reports supplied by the psychologist for legal proceedings.
- Should my account not be paid in full, I would be informed before it will be referred to an attorney, and all legal costs will be for my account.

Father - Name: _____ Signature : _____ Date : _____

Mother - Name: _____ Signature : _____ Date : _____

Guardian - Name: _____ Signature : _____ Date : _____

Person responsible for account -

Name: _____ Signature : _____ Date : _____