Psychological Care Centre

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Account Details and Consent Form

FOR OFFICE USE			
Date of Intake:	**ICD-10 Code:**	**Acc No.:**	**Psychologist:**

CLIENT DETAILS	
Full Name:	Preferred Title / Gender:
Identity Number:	Age:
Cellphone Number:	Work Telephone Number:
Email Address:	Occupation & Employer:
Residential Address:	Postal Address (if not the same as residential):

Client's General Practitioner and Psychiatrist	
Name:	Contact Number:
Name:	Contact Number:

Contact Person(s) in Case of Emergencies	
Name and Relationship:	Contact Number(s):

If the Client is a School Boarder or University Resident	
Houseperson's / Warden's Name:	Contact Number:

MEDICAL AID	
Scheme name:	Plan / Option:
Main Member:	Main Member DOB:
Member No.:	Dependent Code:

PERSON RESPONSIBLE FOR ACCOUNT (if not the client)	
Full Name:	
ID Number:	Address:
Cell No.:	
Work No.:	
Email:	

POPIA DECLARATION AND CONSENT

PLEASE READ THE FOLLOWING PRIOR TO SIGNING THIS DOCUMENT:

The **practice collects and stores information about you** in order to adhere to its administrative requirements and to enable your practitioner to continually assess, treat, and manage your clinical best interest. The **practice will use your personal information only for the purposes** for which it was collected and agreed with you, and it may disclose your personal information to our service providers who are involved in the delivery of services to you (e.g., for billing purposes). The practice has agreements in place to ensure that these service providers comply with **Protection of Personal Information Act 4 of 2013 (POPIA)** privacy requirements. The practice will, on an on-going basis, continue to **review our security controls and related processes to ensure that your personal information remains secure**. You have the right to request a copy of the personal information we hold about you. Please note that any such access request may be subject to the payment of a legally-appropriate fee.

1. I hereby **declare that the above details provided are correct**, and I undertake to notify the Psychological Care Centre of any changes to my particulars.

2. I certify that **I am personally responsible for fees** charged by the Psychological Care Centre, and I understand that all **accounts are payable by the last day of the treatment month**.

3. I am aware that from 01 June 2022 **outstanding accounts that are more than 60-days overdue will be subject to 1.5% interest per month**, unless otherwise discussed with your psychologist. In this latter case, it is your responsibility to make sure that the Office Administrator is aware of any agreed-upon payment plan.

4. Furthermore, I understand that **outstanding accounts that are long overdue will be handed over for debt collection**, and that I will be liable for all legal costs on the scale as between attorney and own client. I understand that it will be at the psychologist's discretion if and when this action is taken, but I will be made aware if and when this action does occur.

5. If I would like the Psychological Care Centre to submit accounts to my medical aid on my behalf, **I understand that it is my responsibility to ensure that I have medical aid cover for psychotherapy benefits** out of hospital. **Should my medical aid not settle my account, I understand that I am responsible for settlement thereof.**

6. **24-HOUR CANCELLATION AND MISSED APPOINTMENTS POLICY:** I understand that if I need to cancel or reschedule an appointment, I will do so 24-hours prior to a booked appointment. **I understand that failing to do so, without a reasonable and valid reason, will result in my being charged the full fee for the appointment**. I understand and accept this condition, recognizing that professional time has been set aside for me. Please note that medical aids do not cover appointments not kept and that clients are therefore liable for the full amount charged. **I understand and accept that this condition also applies to missed appointments without a timeous and reasonable explanation.**

7. **By signing this document, I also confirm that I have been provided with an information document, that I have read it, and that I am willing and able to provide informed consent for services to be rendered to myself, or to a minor for whom I am legally responsible.**

Client's / Guardian of Minor Client's Signature: ______________________________ Date: ____________________

Signature of Person Responsible for Account: ______________________________ Date: ____________________