**INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES (PSYCHOTHERAPY)**

Please fill in the relevant sections prior to your psychotherapy session to secure your appointment. Fill in Form A & B for **Couples Therapy**, Form A & C for **Individual (Adult/Teen) Therapy**, or Form A & D for **Child Therapy**.

The consent form provides important information regarding the professional psychological services offered to you. Please read it carefully and make a note of any concerns and/ or questions you might have. These can be discussed and/or answered prior to any commitments or commencement of psychological services offered to you by a qualified Clinical Psychologist, registered with the Health Professions Council of South Africa (HPCSA) and Board of Healthcare Funders (BHF)**.**

**FORM A - BILLING INFORMATION**

TO BE FILLED BY CLIENT(S)
Please fill in the following tables with information that is important for payment(s) and/or medical aid claims

| **Details of Person Financially Responsible for the Account:**<br>*By providing the information below, you acknowledge that the individual is aware of such responsibility, and gave you consent to make such information available.* | |
|---|---|
| **Names and Surname** | |
| **Date of Birth** | |
| **ID Number** | |
| **Marital Status** | |
| **Relation to Client(s)** | |
| **Occupation** | |
| **Home Language** | |
| **Cell Number** | |
| **Alternative Number** | |
| **Email Address** | |
| **Medical Aid Information:**<br>*By providing the information below, you are consenting for the treating psychologist to claim for sessions you're your medical aid scheme.* | |
| **Medical aid scheme** | |
| **Main member** | |
| **Membership plan** | |
| **Membership number** | |
| **Dependent number** | |
| **Home address** | |

**EMERGENCY CONTACT DETAILS**

In the event of an emergency, such as when one is in physical or emotional danger to themselves or others, the clinician is legally obligated to warn the person in danger, and/or in a position to contact a third party to help mitigate the danger to self and/or to others.

| **Details of Emergency Contact Person:**<br>*This is a trusted individual that can be contacted in the event of an emergency. By providing this information, you acknowledge that the individual is aware of such responsibility, and gave consent to make such information available* | | |
|---|---|---|
| | **Client A** | **Client B** |
| **Names and Surname** | | |
| **Date of Birth** | | |
| **Relation to Client(s)** | | |
| **Home Language** | | |
| **Home Address** | | |
| **Cell Number** | | |
| **Alternative Number** | | |



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153 River Road, Lyttelton Manor
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## FORM B - INFORMED CONSENT FORM FOR COUPLES/FAMILIES

Names and Surname : _____ & _____.
Date Of Birth (DOB) : _____ & _____.
Identity (ID) Number : _____ & _____.
Contact Details : _____ & _____.

We _____ (names) hereby voluntarily consent to:

- Receiving confidential psychological services (including screenings, assessments, psychotherapy, etc.)
- Confidentiality limitations; i.e. Reported/observed harm to self or others.
- Audio/video recording of the session (done with additional consent).

***NOTE:*** *Where specific requests are received to disclose information contained in your records, a separate consent form to disclose, detailing the content to be disclosed, will be provided to you.*

- Financial responsibility to pay for the provided psychological services (including screenings, assessments, psychotherapy, etc.)
- Ensure funds are available prior to setting an appointment so that medical aid claims are not delayed.
- Cancel appointments within at least 24 hours should the need arise.
- Liability to pay 50% of the fee if an appointment is cancelled without the 24hour notice, unless discussed otherwise.
- Liability to pay 100% of the fee if an appointment is missed without cancellation.

***NOTE:*** *The standard cash fee for a psychotherapy session is R950 for individuals, and R1300 for couples or families. However, for those with medical aid scheme membership, medical aid rates apply.*

- The discussion of our clinical information by a multi- professional team where need be.
  All patient's/ clients rights are protected in terms of the regulations set by the Health Professions Council of South Africa (HPCSA).
- Undergo any necessary psychometrics tests and treatment recommended.
- Reports being obtained by/from other authorised and appropriate sources (e.g. school, employer, GP, psychiatrist, court of law, etc.)

***Please note that psycho-legal/medico-legal reports requested will be provided by the treating psychologist at an additional cost.***

We acknowledge that we had the opportunity to carefully read this document, to ask questions, or to communicate concerns arising from it. We further acknowledge that we have read and understand the information contained in this document, and that we give our consent willingly on the____day of _____20___.

_____. _____.
Client A Signature Signed at

_____. _____.
Client B Signature Signed at

Treating Clinician's Signature: _____.



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## FORM C - INFORMED CONSENT FORM FOR INDIVIDUALS (ADULTS & TEENS)

Names and Surname : _____.
Date Of Birth (DOB) : _____.
Identity (ID) Number : _____.
Contact Details : _____.

I _____, hereby voluntarily consent to:

- Receiving confidential psychological services (including screenings, assessments, psychotherapy, etc.)
- Confidentiality limitations; i.e. Reported/observed harm to self or others.
- Audio/video recording of the session (done with additional consent).

***NOTE:*** *Where specific requests are received to disclose information contained in your records, a separate consent form to disclose, detailing the content to be disclosed, will be provided to you.*

- Financial responsibility to pay for the provided psychological services (including screenings, assessments, psychotherapy, etc.).
- Ensure funds are available prior to setting an appointment so that medical aid claims are not delayed.
- Cancel appointments within at least 24 hours should the need arise.
- Liability to pay 50% of the fee if an appointment is cancelled without the 24hour notice, unless discussed otherwise
- Liability to pay 100% of the fee if an appointment is missed without cancellation.

***NOTE:*** *The standard cash fee for a psychotherapy session is R950 for individuals, and R1300 for couples or families. However, for those with medical aid scheme membership, medical aid rates apply.*

- The discussion of our clinical information by a multi- professional team where need be.
  All patient's/ clients rights are protected in terms of the regulations set by the Health Professions Council of South Africa (HPCSA)
- Undergo any necessary psychometrics tests and treatment recommended.
- Reports being obtained by/from other authorised and appropriate sources (e.g. school, employer, GP, psychiatrist, court of law, etc.)

***Please note that psycho-legal/medico-legal reports requested will be provided by the treating psychologist at an additional cost.***

I acknowledge that I had the opportunity to carefully read this document, to ask questions, or to communicate concerns arising from it. I further acknowledge that I have read and understand the information contained in this document, and that I give my consent willingly on the__day of _____20___.

**FOR ADOLESCENTS ONLY:**

1. Do your parent(s)/guardian(s) know that you are attending psychotherapy _____.
2. If no, please elaborate on the reason _____
   _____
3. Are you open to having your parent(s)/guardian(s) know about you receiving psychological services? _____
4. If no, please elaborate on the reason: _____
   _____

Client A Signature: _____ Signed at: _____

Treating Clinician's Signature: _____.



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## FORM D - INFORMED CONSENT FORM FOR MINORS

Minor's Names and Surname : _____.
Date Of Birth (DOB) : _____.
Identity (ID) Number : _____.
Contact Details : _____.

We, (PARENT/GUARDIAN) _____ and _____, parents/guardian of _____ hereby voluntarily consent for our/my child to:

- Receive confidential psychological services (including screenings, assessments, psychotherapy, etc.)
- Confidentiality limitations; i.e. Reported/observed harm to self or others.
- Audio/video recording of the session (done with additional consent).

***NOTE:*** *Where specific requests are received to disclose information contained in your records, a separate consent form to disclose, detailing the content to be disclosed, will be provided to you.*

- Financial responsibility to pay for the provided psychological services (including screenings, assessments, psychotherapy, etc.).
- Ensure funds are available prior to setting an appointment so that medical aid claims are not delayed.
- Cancel appointments within at least 24 hours should the need arise.
- Liability to pay 50% of the fee if an appointment is cancelled without the 24hour notice, unless discussed otherwise
- Liability to pay 100% of the fee if an appointment is missed without cancellation.

***NOTE:*** *The standard cash fee for a psychotherapy session is R950 for individuals, and R1300 for couples or families. However, for those with medical aid scheme membership, medical aid rates apply.*

- The discussion of his/her clinical information by a multi- professional team where need be.
  All patient's/clients rights are protected in terms of the regulations set by the Health Professions Council of South Africa (HPCSA)
- Undergo any necessary psychometrics tests and treatment recommended.
- Reports being obtained by/from other authorised and appropriate sources (e.g. school, employer, GP, psychiatrist, court of law, etc.)

***Please note that psycho-legal/medico-legal reports requested will be provided by the treating psychologist at an additional cost.***

We acknowledge that we had the opportunity to carefully read this document, to ask questions, or to communicate concerns arising from it. We further acknowledge that we have read and understand the information contained in this document, and that we give our consent willingly on the____day of _____20___.

Parent/guardian Signature_____. Parent/guardian Signature _____.

Signed at_____ Signed at _____.

If only one parent gave consent, please provide reason _____.

_____.
Treating Clinician's Signature

_____
Signed at



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