Ushmita Nana

COUNSELLING PSYCHOLOGIST

MA Couns Psych (UJ), BSc Hons (UNISA), BSc (UNISA)

Practice Areas: Lenasia and Roodepoort
Phone Number: 071 685 4902
Email: ushmitanana@gmail.com

HPCSA: PS 0134007
BHF : 0860020664537

CLIENT INFORMATION FORM

CLIENT DETAILS **File number: _____** *(Office Use)*

Surname: .....

Full Names: .....

Date of Birth: .....ID Number: .....

Contact Number: ..... Alternative Contact Number: .....

Postal Address: .....Code:.....

Home Address: .....

E-Mail Address: .....

Person to Contact in an Emergency: ..... Contact Number: .....

From where did you hear about this practice? ☐ Newspaper ☐ Internet ☐ Social Media ☐ Referral

Referred By: ..... Referral Contact Number .....

DETAILS OF THE PERSON RESPONSIBLE FOR THE ACCOUNT *(If not the client)*

Surname: .....

Full Name: .....

Title: ..... ID Number: .....

Relationship to Client: ☐ Spouse / Life Partner ☐ Parent ☐ Employer ☐ Other

Postal Address: .....Code: .....

Home Address: .....

Telephone/Contact numbers: .....Email Address: .....

Employer (company name): ..... Employer Tel nr:.....

MEDICAL AID DETAILS *(complete if applicable)*

Medical Aid Name: .....

Main Member Name: .....

Member Number: ..... Plan Type: .....

Client Dependent Code: .....

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INFORMED CONSENT

NATURE OF PSYCHOLOGICAL INTERVENTION:

☐ Couples Therapy ☐ Individual Therapy

☐ Psychoeducational Assessment ☐ Career Assessment

PSYCHOLOGICAL HISTORY:

1. Have you seen a Professional prior to this appointment? Y/N
2. Do you have any reports to submit to the Professional from other Health Care Practitioners? Y/N

BENEFITS OF THERAPY

Therapy can help a person to gain new understandings about his/her problems and to learn new ways of coping with and solving those problems. Therapy can help a person to develop new skills and to change behavior patterns. It is the client's responsibility to mention any concerns or questions that he or she may have at any time during the process of therapy to the therapist.

MEDICAL AID AND FEE PAYMENT

1. I am aware and consent to my information (including diagnosis and treatment information) being shared with my Medical Scheme if my account is submitted to my Medical Scheme for reimbursement. This practice makes use of a Medical Billing Software to assist with submission of all Medical Aid claims, accordingly my personal information will be shared with the Software Company to assist with processing my account for payment. I hereby consent to this disclosure.
2. Legislation compels the practice to provide certain information to the medical scheme on the accounts and failure to submit the correct codes might lead to the claim being incorrectly paid or rejected. The Medical Schemes Act states that an account submitted to a medical scheme must contain the relevant

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diagnosis. This must be submitted as an ICD-10 diagnostic code and it has become necessary to include these ICD-10 codes on referral letters, requests for special investigations (e.g., radiology, pathology) etc.

3. I understand that if the practice forwards an account for payment to my medical scheme for reimbursement, the principal member of the medical scheme may become aware of the account, thus compromising my confidentiality.
4. Consultation fees are in accordance with the fees recommended by the National Health Reference Price List as published by the Department of Health and are in line with most medical aid rates. Consultation fees are subject to annual increase.
5. Medical aids sometimes pay less than the therapy fee. Sometimes they do not pay at all. **Note that the client will still have to pay the full account, even if the scheme does not pay in full.**
6. **A notice period of 24 hours is required for cancellation and rescheduling of appointments, otherwise the full session fee will be charged as the timeslot could have been allocated to another client. The session charge is also applicable to "no show" appointments.**
7. The client is responsible for attending their session on time and at the timeslot which had been mutually agreed. **The session duration is 50 minutes.** If the client is late, the session will still end at the scheduled end time. The therapist will only wait 15 minutes after commencement time of the session if the client is running late. Since such actions might cause inconvenience to other clients waiting for a session, these sessions will be charged in full and the client is liable for the account.

ONLINE THERAPY

Online therapy utilizes the internet for the transmission of personal information and therefore, there are increased risks to confidentiality. Please consider password protecting the devices you use. Your information remains secure and only available to me. When I am in contact with you, I will ensure that I am in a confidential and private space where no one else can hear or see the online interaction. Please can you make sure that you are also in a confidential space where no one else can see or hear your interaction.

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Disruptions can occur when using the internet to communicate. Should our communication be disrupted, I will immediately attempt to reconnect and resume the session. However, if repeatedly unable to reconnect for 10 minutes, the session will be rescheduled to a later date once connectivity is resumed.

By consenting, you agree to the following:

- I agree that I am aware that I am responsible for securing my computer hardware, internet access points, and password security
- I am responsible for making sure that when the consultation takes place, I am in a safe, confidential, and private place
- I am responsible for my equipment and do not hold the psychologist liable for equipment failure, e.g. camera, and/or Internet service.
- I agree that I am not allowed to make an audio or video recording of any portion of the session.

In knowledge and appreciation of the benefits and risks as made known to me by the therapist and as reflected on this form, I …….
hereby give consent to willingly participate in therapy/assessment for the sake of addressing the following:
……
……
……
……

CONFIDENTALITY AND LIMITS ON CONFIDENTIALITY

I have been advised by the therapist that all communications with me and all records relating to the provision of psychological services to me are confidential and may not be disclosed without written informed consent. I have also been advised by the therapist that the law places certain limits on the confidential nature of the psychological services provided to me. I have been advised that typically these limits on confidentiality may arise if the therapist perceives that there is a risk of harm in situations such as the following:

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1. I am in imminent danger to myself, or present a danger to others or report that my life is threatened by someone, the law requires that steps be taken to prevent such harm.
2. If a court orders the disclosure of records.
3. Guidelines of confidentiality and limits on confidentiality do not apply to psycho-legal work as reports are requested by courts and law practitioners.

COMPLIANCE WITH THE PROTECTION OF PERSONAL INFORMATION ACT (POPIA)

1. I understand that this practice takes the privacy of its patients very seriously and has implemented reasonable security measures to guard against the unauthorised disclosure of my private patient information.
2. This document constitutes a contractual agreement with the practice to protect all personal information in confidence. We will use the patient's information only in relation to providing healthcare, which means that we may also use the information when we interact with your Medical Aid or when processing your account.
3. I confirm that all information supplied by myself is true and correct and that I am responsible for updating my information to ensure that it is correct and for not providing any false information.
4. I acknowledge that my personal and special personal information will be kept for the required storage and retention periods according to and in line with legislation periods applicable to the practice and the medical/ healthcare industry.
5. In the event of a third-party request for confidential information from the practice, and in doubt regarding the safety of confidentiality processes, the practice may insist on following the processes stated in the Promotion of Access to Information Act (PAIA). Requests for access to information kept by the practice can be lodged with the Information Officer of the practice.
6. I acknowledge that my patient information may be disclosed by the practice in response to a specific request by a law enforcement agency, subpoena, court order, or as required by law.

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ACKNOWLEDGEMENT AND CONSENT

I, ……. , the undersigned, acknowledge that I have had the opportunity to carefully read this document and to ask, and have answered, any questions or concerns I have about it or arising from it. I further acknowledge that I have read and understood the information contained in this documentation, that it records my informed consent.

_____ _____

FULL NAME(S) AND SURNAME **SIGNATURE**

_____

DATE