

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:

- | | |
|---|---|
| <input type="checkbox"/> Couples Therapy | <input type="checkbox"/> Individual Therapy |
| <input type="checkbox"/> Psychoeducational Assessment | <input type="checkbox"/> 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. The law on medical aids forces medical professionals to provide certain information to the medical aid. When the client submits his or her account to the medical aid, the account includes personal information, such as health status, and the codes (numbers) that indicate the specific therapy the client has received and the ICD-10 codes on the client's diagnoses.
2. 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.

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3. 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.**
4. **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.**
5. 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.

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

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- 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:

.....
.....
.....
.....

CONFIDENTIALITY 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:

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.

I AM AWARE OF THE FOLLOWING REGARDING THE POPI ACT POLICY:

- We collect and store the information about you in order for us to adhere to administrative requirements of the practice

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- We collect and store information about you in or order for us to continually assess, treat and manage your clinical best interest.
- We will use your personal information only for the purposes for which it was collected and agreed with you
- We may disclose your personal information to our service providers who are involved in the delivery of services to you (i.e for billing purposes).
- We have agreements in place to ensure that they comply with the privacy requirements as required by the Protection of Personal Information Act.
- We 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 a payment of a legally allowable fee

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