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

INFORMED CONSENT

PARENTAL AGREEMENT TO INTERVENTION FOR A MINOR

Parent/Legal Guardian (1)

Surname: ……

Full Name: ………

Title: …………………………… ID Number: …………………………………………………………………………………………

Relationship to Client: ……….

Telephone Number Home: …….

Telephone Number Work: ……

Cellphone Number: ……..

Email Address: …….

Responsible for Payment of Account? Y/N

Parent/Legal Guardian (2)

Surname: ……

Full Name: ………

Title: …………………………… ID Number: …………………………………………………………………………………………

Relationship to Client: ……….

Telephone Number Home: …….

Telephone Number Work: ……

Cellphone Number: ……..

Email Address: …….

Responsible for Payment of Account? Y/N

Are the parents:

☐ Married ☐ Divorced ☐ Single ☐ Separated

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Who has legal custody of the minor?

☐ Mother ☐ Father ☐ Joint ☐ Legal Guardian

Medical Aid Details:

Medical Aid: ……..

Main Member Name: ……………………………………………………………………………………………………….

Member Number: ……….

Plan Type: ………

Funds Confirmed? Y/N

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.
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. First time cash agreement accounts must be paid at the time of booking the appointment. The fee can be paid via EFT or cash. Should fees remain unpaid, the therapist retains the right to terminate services as this prohibits the therapist from earning an income. However, in such circumstances the therapist will offer the client referrals to other sources of care.
5. **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.**
6. 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

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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.

7. Assessments are billed in advance; specific arrangements will be communicated when assessments are booked.

Please see banking details below:

Bank: Absa Bank

Branch Code: 632005

Account Name: Ushmita Nana

Account Number: 4090752110

Reference: Client's last name and date of appointment

THE PROCESS 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 can also facilitate the mobilization of existing resilience and resources. I/we understand that it is important that I/we mention any concerns or questions that I/we may have at any time during the process of therapy to the therapist. Please note that the parent(s)/guardian(s) will be requested to attend an intake session before therapy commences with the minor. This session is necessary in order to obtain background information which is useful in the therapeutic process. As such, the intake session is billed at the rate of a therapy session.

INFORMED CONSENT

In knowledge and appreciation of the benefits and risks as made known to me/us by the therapist and as reflected in this form, I/we hereby give consent that the minor

……………………………………………………………………………………………, willingly participates in therapy for the sake of addressing …….

………..

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CONFIDENTIALITY AND THE LIMITS TO CONFIDENTIALITY

I/we have been advised by the therapist that all communications with me/us or with my/our child and all records relating to the provision of psychological services to me/us are confidential and may not be disclosed without written informed consent. I/we have also been advised by the therapist that the law places certain limits on the confidential nature of the psychological services provided to me/us. I/we 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:

- If a minor presents an imminent danger to him/herself or others, the law requires that steps be taken to prevent such harm.
- If a minor is in need of protection, a report must be filed with the appropriate agency or authority.
- If a court orders the disclosure of records.
- Guidelines of confidentiality and limits on confidentiality do not apply to psycho-legal work, as reports are requested by courts and law practitioners.

ACNOWLEDGEMENT OF CONSENT

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

_________________________	___________________
FULL NAME AND SURNAME OF PARENT/LEGAL GUARDIAN (1)	**SIGNATURE**
_________________________	___________________
FULL NAME AND SURNAME OF PARENT/LEGAL GUARDIAN (2)	**SIGNATURE**

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INTAKE FORM FOR A MINOR

Biographical Information

Child's Full Name:………………………………………………………………………………………………… Age: ……………….

ID Number: ………………………………………………….. Home Language: ……………………………………………………….

School: ………………………………………………… Grade: ……………………………………………………………………..

Home Address: ……..

Are Both Parents Living? …….

If not, provide year of death: …………………………………………………………………………………………

Child's reaction to the death: …………………………………………………………………………………………

………

………

If both parents are living, parents' marital status: …………………………………………………………………….

If divorced or separated who do the children reside with? …………………………………………………….

Does the child have interaction with both parents? ……………………………………………………………….

Are the parents in a same-sex relationship? ………………………………………………………………………….

If so, describe the child's response to the relationship: ……………………………………………………..

……

……

Presenting Circumstances

Reason for seeking therapy:

………

………

………

………

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………

………

………

What, if any, stressors is your child experiencing in the current life situation in terms of peer interaction, school, family, legal issues, etc?

………

………

………

………

Has your child been in therapy before? If so, please provide further detail:

………

………

………

………

Developmental History and Medical History

Where there any birth-related complications? ……………………………………………………………………………

If so, please describe: ……………………………………………………………………………………………………

……

Has your child had any problems with Eating, Sleeping or Separation? ……………………………………

If so, please describe: ……………………………………………………………………………………………………

……

……

Is your child on any medication? ……………………………………………………………………………………

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If so, please provide further detail: ……………………………………………………………………………..

……..

……..

Has the child had any major medical issues such as chronic illness, injury, head trauma or surgery? Y/N

If so, please describe:……………………………………………………………………………………………………..

……..

……..

Family Information

Names, Gender and Ages of Siblings/Half Siblings:

……….

……….

……….

……….

What is the child's relationship like with the siblings?

……….

……….

……….

……….

What is the child's relationship like with the parents?

……….

……….

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………

………

Do any extended family members play a role in the child's life? Y/N

If yes, please elaborate:

………

………

………

Have there been any deaths in the immediate family in the past 12 months? Y/N

If yes, please elaborate:

………

………

………

Has there ever been any concerns relating to domestic violence, physical or sexual abuse in the family? Y/N

If yes, please elaborate:

………

………

………

School Information

Describe any changes to school performance:

………

………

………

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Describe the child's relationship with peers and teachers:

……

……

……

Elaborate on any instances of bullying:

……

……

……

Personality

How would you describe your child?

……

……

……

What are his/her strengths?

……

……

……

What are his/her vulnerabilities?

……

……

……

How do you think that others would describe your child?

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……
……
……

Social Circumstances

Who would you consider your friends support system i.e. friends, family, etc?

……
……
……

How do you discipline your child?

……
……
……

How effective is this discipline strategy?

……
……

How does your child spend his/her leisure time?

……
……

As a family, how do you spend leisure time?

……
……

Does both parents work? Y/N

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If so, full day or half day? ……

Traumatic Events

Has your child experienced anything that you consider to be traumatic at present or from their past?

……

……

……

Other

Is there anything that has not been mentioned that you would like to add?

……

……

……