Clinical
Psychologist
MARIET TERBLANCHE

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Pr. No: 9990860010964638
PS: 0098043
BA, BA Hons (Industrial Psych), MA (Industrial Psych)
BA Hons (Clinical Psych), MA (Clinical Psych)

1. PATIENT

Surname			**Title**		
Full name		**Nickname**			
Date of birth			**Age**		
Minor patient: Names of both parents	**Mother:**	**Father:**			
Address	**Home:**	**Address:**			
Contact number		**Email:**			
Referred by:					
Current medication					

2. PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

Surname			**Title**		
Full name		**Nickname**			
Date of birth		**ID**			
Relationship to patient					
Medical Scheme		**Member Number**		**Plan**	
Address: If different from above	**Home**	**Po Box**			
Contact number		**Email:**			
Profession		**Employer**			
		Work contact number			
Name of friend/ family member who can be contacted	**Regarding account**	**In case of emergency**			
Contact number					

3. INFORMED CONSENT

I, (full names) _____ the undersigned, hereby grant the Clinical Psychologist consent to engage in a therapeutic process with myself and/or my minor child: _____ (Name of minor child)

3.1 I understand that I have the right to discontinue treatment if I feel that there is insufficient progress being made.
3.2 I understand that the Psychologist may terminate treatment if she is of the opinion that the patient is not giving his/her cooperation.
3.3 I accept that, should the outcome of the therapy not be what I expected, I cannot seek any legal action against the psychologist in terms of her professionalism and competence.
3.4 I undertake to notify the **practice 24 hours** in advance if an appointment cannot be kept.
3.5 I accept that the practice reserves the right to charge a cancellation fee **of R300** directly from me and not from my Medical Scheme if I do not cancel timeously. I realise that the session is reserved for me and that another patient can therefore not be accommodated.

_____ _____ _____

Signature **Date** **Witness**

PATIENT FINANCIAL POLICY

The patient financial policy has been developed to assist in answering your questions regarding patient and Medical Scheme responsibility for services rendered. Your understanding of and compliance with this policy is important. My practice relies on payment from both Medical Schemes and patients to cover expenses. Please read this notice carefully and feel free to question any item(s) that you do not fully understand.

I am dedicated to provide the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. The original document will be retained in your file and a copy can be provided to you on request.

1. **PROOF OF MEDICAL SCHEME COVERAGE**: It is your responsibility to ensure that we have your correct information and an up-to-date copy of your Medical Scheme benefit card and a copy of your identity document.
2. **UPDATED CHANGE OF INFORMATION & COVERAGE**: It is your responsibility to make us aware of any change in address, employment, Medical Scheme plan, option, benefits, etc. If you fail to provide us with the correct updated information, you will be responsible for the entire cost of the services rendered and immediate payment will be expected.
3. **PAYMENT**: If you are responsible for payment of services, we will accept cash and electronic bank transfers. Payment will include any unmet co-payment amount, or non-covered charges from your Medical Scheme company. Insurance is a contract between the patient and the Medical Scheme company and ultimately the patient is responsible for payment in full. If your Medical Scheme does not pay the practice within a reasonable period, you will be billed. Overpayment to the practice will be reimbursed to you.
4. **NON-COVERED SERVICES**: Some services you receive may not be covered by your Medical Scheme plan. If you elect to have these services, payment in full at the time of service will be expected.
5. **AUTHORISATIONS**: All Medical Scheme benefit plans for Psychology differs. It is your responsibility to understand your benefit plan and to know if a written referral or authorization is required to see a psychologist and what services are covered by your policy. Prior authorization for services is not a guarantee of payment of benefits.
6. **CLAIMS SUBMISSION**: We will submit your claims and assist you in any way we can to help get your claims paid. Your Medical Scheme administrator may request information directly from you. Your failure to timely comply with your Medical Scheme's request may result in your claim denial and if so, will result in our seeking full reimbursement from you for services rendered. Your Medical Scheme benefit is a contract between you and your Medical Scheme provider. Problems identified by your Medical Scheme, will be sent to you on your statement. Please contact your Medical Scheme immediately to resolve these issues to prevent the charges from becoming your responsibility.
7. **DIAGNOSTIC CODES (ICD 10):** Please take note that a diagnostic code (ICD 10 code) is required by your Medical Scheme for services rendered. You hereby agree that the ICD 10 code can be submitted to you Medical Scheme via our Administrative Officer.
8. **PAYMENT DIRECTLY TO YOU**: If your Medical Scheme send payment directly to you for services rendered, our charges for you are due at the time of service. You are expected to pay our practice within 48 hours of receiving payment from your Medical Scheme.
9. **PAYMENT METHODS**: We accept cash and EFT as payment for services rendered. Payment and credits are applied to the oldest charges first, except for Medical Scheme payments which are applied to the corresponding dates of service.
10. **NO SHOW POLICY**: A cancellation fee of **R 300** is payable if an appointment is not cancelled at least 24 hours prior to the consultation. If you miss 2 more visits without cancelling or rescheduling **24 hours** in advance, you may be dismissed from the practice.
11. **DIVORCED PARENTS OF PATIENTS**: The adult parent who signs a minor child into the practice accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs the child into the practice. Parents are responsible to communicate with each other about treatment and payment issues.
12. **NON-PAYMENT**: If your account is over 60 days past due, you will receive a statement indicating that you have 30 days to pay your account in full. Partial payments will not be accepted unless you have contacted our office and otherwise negotiated. Please be aware that if a balance remains unpaid, we will turn your account over to a collection agency after the 90th day past due. Should it be necessary to collect any monies from you in terms hereof, you hereby accept responsibility for payment of all legal fees in connection therewith, on scale as between attorney and own client, including costs such as tracing fees and collection commission.

13. **GENERAL**: You accept that the psychologist is under no obligation to draw up written reports of any nature relating to any services offered. Should the psychologist undertake to draw up a written report, the time spent drawing up the report will be charged at the hourly Medical Scheme rate for psychotherapy. Should it be necessary for the psychologist to draw up psycho-legal reports of any nature whatsoever, or to appear in court for any reason related to any service offered, the time utilised for these purposes will be charged for at the above-mentioned tariffs. Please note that Medical Schemes do not cover this charge. You therefore undertake to accept responsibility to make full payment on receipt of any such report.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time and that I have the right to be informed of such changes beforehand.

Signed at _____ on this _____ day of _____ 20_____

Signature _____ **Id number _____**

INFORMED PERMISSION TO MAKE CONFIDENTIAL INFORMATION AVAILABLE

The Protection of Personal Information Act, 2013 (POPIA), protects and upholds the right to privacy by protecting personal information. To comply with the requirements of this legislation it is essential for the practice to obtain your informed consent to share some of your personal information regarding psychotherapy/services rendered to institutions such as your Medical Scheme/other health professions and/or persons/institutions involved in your treatment.

Note that no personal information may be shared without your consent and no documentation regarding your personal information will leave this practice without your written consent.

I, _____ (full names and surname) with ID number _____ hereby give
informed consent to the Clinical Psychologist, Mariet Terblanche, Practice Number 9990860010964638 to release the following confidential information in the following ways:

	Person/Institution with whom information may be shared:	**Information that may be shared**	**Mark with X where applicable**
1.	Medical Scheme:	ICD 10 Diagnostic Code	
		Motivation for services (written and telephonic)	
2.	Family doctor: Doctor's name	Written referral/telephonic referral/diagnosis/ prognosis/treatment plan	
3.	Psychiatrist: Name of psychiatrist	Written referral/telephonic referral/diagnosis/ prognosis/treatment plan	
4.	Reports:	Type of report: To whom directed:	
5.	Information regarding minor child	Feedback regarding: Feedback to:	
6.	Other:	Feedback regarding:	

I understand the implications for disclosing the above information and will not hold the psychologist, Mariet Terblanche in any way liable for any damages whatsoever which may occur due to disclosure of the above confidential information.

_____ _____ _____

Signature **Date** **Witness**