REFLECTION PSYCHOLOGY
PO Box 770, Camberwell South LPO 3124 ABN 46 766 975 046
03 **9809 4888** 03 **9809 4555**
enquiries@reflectionpsychology.com.au
www.reflectionpsychology.com.au

Confidential Client Registration and Consent Form

Date: _____

Client Details:

Title: _____ First name: _____ Surname: _____

Date of Birth: _____ (DD/MM/YYYY)

Postal Address: ☐ *Please tick if you do NOT wish to receive mail to this address*

(Street): _____

(Suburb): _____ (State): _____(Post code):_____

Phone: *Please tick if you do NOT wish to have messages left on your message bank*

(mobile) ☐_____ (home) ☐_____ (work) ☐_____

Did you receive a phone call from your psychologist before today's appointment? ☐ Yes ☐ No

E-mail: *Please print* _____

Would you like an SMS reminder 48 hours before your appointment? ☐ Yes ☐ No

Occupation: _____

Medicare #: _____ IRN: (*# next to name*) _____ Expiry: _____

Do you have a health care card? ☐ Yes ☐ No Health care card expiry date: _____

Cancellation Policy:

To avoid a cancellation fee, **Reflection Psychology** requires 48 hours notice (to the hour). A **50% consultation fee** will occur if less than **48 hours notice** is received and a **100% consultation fee** will occur if less than **24 hours notice** is received. This includes cancellations, rescheduling or failure to attend appointments. Reflection Psychology has put in place this cancellation policy to ensure that enough time is provided to offer the appointment time to another client. If less notice is provided, other clients may miss out on obtaining the psychological services they require. Amendments to appointments must be made via phone (voice messages accepted). Please note: A Debt Collection service may be used to collect outstanding debts not paid. Please contact management for more information.

I accept that I will be charged a cancellation fee if I fail to give 48 hours notice when canceling or rescheduling my appointment, or if I fail to attend my appointment without cancellation.

Client signature: _____ date

(Signature, full name or initials accepted)

Bank Details (Optional): Medicare requires that your bank details are registered for automatic online claiming of your Medicare benefits.

Note: If you have previously registered your bank details with Medicare, your rebate will automatically be credited to your nominated bank account. You will NOT need to fill this section.

Bank account name (e.g. John Smith): _____

Bank account number: _____

BSB code: _____

Have you claimed Medicare benefits with a psychologist in the last 12 months? ☐ Yes ☐ No

If yes, how many sessions did you claim? _____

Emergency Contact Details

Name:_____ Relationship: _____ Contact Number:_____

Personal and Confidential Information:

As part of providing a psychological service, **Reflection Psychology** will need to collect and record personal information from you that is relevant to your current situation. This information will be a necessary part of the psychological assessment, diagnosis and treatment that is conducted. The information is retained in order to document what happens during sessions, and enables the psychologist to provide a relevant and informed psychological service.

All personal information gathered by the psychologist during the provision of the psychological service will remain confidential and secure except where:

1. It is subpoenaed by a court, or
2. Failure to disclose the information would place you or another person at serious and imminent risk; or
3. Your prior approval has been obtained to
    a) provide a written report to another professional or agency. eg. a GP or a lawyer; or
    b) discuss the material with another person, eg. a parent or employer; or
    c) if disclosure is otherwise required or authorised by law.

Reflection Psychology will amend personal information recorded on this form upon your written request.

Charter for Clients of Psychologists
The attached Charter explains your rights as a client of a psychologist.

I, (print name) _____ have read and understood the above information regarding Personal and Confidential information, and the APS Charter. I agree to these conditions for the psychological service provided by **Reflection Psychology**.

Signature _____ Date _____
(Signature, full name or initials accepted)

How did you hear about us?

(Please select one from the drop down)

Please email reception@reflectionpsychology.com.au or call 03 9809 4888 if you have any questions about this form.