Claire Maher

Educational Psychologist

BSocSc (UKZN), BSocSc Hons Psychology (UKZN), PGCE (UKZN), M.Ed (Psych) (Wits)

Practice Number: 0483664 • HPCSA Registration Number: PS0119652

IDENTIFYING PARTICULARS OF DEPENDANT (CLIENT)			
Surname:		First name/s:	
Date of birth:	Age:	School:	Grade:

PARENT/GUARDIAN PARTICULARS	
Marital status:	
Parent/Guardian 1 details:	Parent/Guardian 2 details:
Surname:	Surname:
First name/s:	First name/s:
Identity number:	Identity number:
Cell number:	Cell number:
Residential address:	Residential address:
E-mail address:	E-mail address:
Occupation:	Occupation:
Company:	Company:

FAMILY DETAILS (SIBLINGS)			
Name/s:	Date of birth:	Relation to child:	Age:

CONTACT PERSON FOR THE CHILD	
Surname:	First name/s:
Cell Number:	Relation:

MEDICAL AID DETAILS	
Medical aid name:	Main member:
Medical aid option:	Membership number:
Dependent code:	

SOURCE OF REFERRAL (please tick)				
Specialist	G.P	Therapist	Family/Friend	Other
Surname:		First name/s:		
Cell number:				

SIGNED:	**DATE:**
PRINTED NAME:	

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TERMS OF THE PRACTICE

NAME OF PARENT: _____NAME OF CLIENT: _____

DATE: _____

1. TERMS

1.1 Accounts are deemed to have been received five (5) days after despatch and to be correct in all respects unless I notify the Psychologist in writing of any discrepancy or error within a further seven (7) days thereof. I undertake to pay all costs actually incurred by the Psychologist in recovering any amount due including attorney and own client charges, tracing and collection charges and any other costs incurred in proving a claim in the event of death or insolvency.

1.2 I acknowledge that I am personally responsible for the account in respect of both myself and my dependants nominated herein, and it is my responsibility to submit all claims to my Medical Aid for reimbursement.

1.3 I acknowledge that my Medical Aid requires the Psychologist to submit an ICD-10 (International Statistical Classifications of Diseases and Related Health Problems – Version 10 developed by the World Health Organisation for international use in the collection of morbidity and mortality information) diagnostic code in order for my claim to be processed by them. I hereby grant the Psychologist permission to reflect the appropriate ICD-10 diagnostic code on my invoice/statement. I am aware that I have the right to request the use of a non-disclosure code, but that the possibility exists that my Medical Aid may refuse reimbursement based on this.

1.4 The therapeutic hour consists of 45 minutes therapy time and 5 minutes for administrative purposes.

2. LIABILITY

2.1 While fully understanding that the Psychologist will try her best to help me resolve my/my child's problem or symptoms, I fully understand that there is no guarantee that the treatment will be successful.

2.2 I understand that the Psychotherapeutic session might be fully audio- or video taped or both at the discretion of the Psychologist and that these audio- or videotapes will be kept confidential by the Psychologist.

2.3 I understand that I have the right to terminate treatment whenever I wish should I feel that no or inadequate progress is being made.

2.4 I understand that at times treatment may leave me/my child feeling out of sorts.

3. CANCELLATION FEE

3.1 All appointments must be cancelled at least 24 hours before the scheduled time otherwise a full appointment will be charged for in full.

3.2 Should I fail to arrive for any scheduled appointment at the appointed time, I acknowledge that I will be liable for the full fee of that appointment.

Thank you for your understanding and co-operation. The undersigned declares that he/she is familiar with the terms of this practice and that it is accepted as such.

SIGNED: _____