

1. PATIENT DETAILS

Surname	First names	Nickname
Date of birth	ID/ Passport number	
Marital Status	Cell Number	Home Language

2. PERSON RESPONSIBLE FOR ACCOUNT

Surname	First names	Title
ID / passport number		Marital status
Home address		Code
Postal address		Code
Tel: (H)	Tel: (W)	Cell:
Email address that you use to receive all important emails		
Partner's name	Partner's email address	
Partner's contact details	Additional Contact number	

Medical aid name	Medical aid number	
Main member's name	Relationship to client	
Main member's ID number	Dependent code of patient (required)	Plan Type
<u>Please note that all accounts remain your responsibility</u>	Submit to medical aid. (please circle) Yes No	

3. NEAREST FAMILY MEMBER OR FRIEND

Name	Relationship	
Tel:(H)	Tel: (W)	Cell:

Cancellations: Appointments should be cancelled at least 24 hours before the time of the appointment. The client will be responsible for the full payment of the session if the appointment is not cancelled 24hrs in advance, even if the appointment is cancelled because of traffic or medical problems. Monday appointments must be cancelled by Saturday 12pm.

Signature: _____

Date: _____

Guardian Signature: _____

Date: _____

- This practice is contracted in with most major medical aids. Accounts can be submitted to your medical aid on your behalf. However, accounts remain your responsibility if your medical aids do not cover the costs of sessions.
- In the event of the account(s) not being settled in full, the client agrees to pay all credit bureau costs, tracing costs and legal costs for the recovery of outstanding amounts. Interest will be added to the amounts owing monthly according to that charged by financial institutions.
- Full confidentiality is assured at all times. However, under certain circumstances as described by our ethical and professional code, e.g., suicide risk or child abuse, the therapist may need to break confidentiality to assist the client or any vulnerable members of society.
- The Practice/Sophia Combrink cannot take responsibility for any injury, loss or damage to the client/undersigned or their property and cannot be held liable for any accidents that may occur on the premises.

Compliance with the Protection of Personal Information Act (POPIA)

I understand that this practice takes the privacy of its patients and clients very seriously and has implemented reasonable security measures to guard against the unauthorized disclosure of my private information.

This document constitutes a contractual agreement with the practice to protect all personal information in confidence. We will use the patient's information only in relation to providing healthcare, which means that we may also use the information when we interact with your medical aid or when processing accounts.

I confirm that all information supplied by myself is true and correct and that I am responsible for updating my information to ensure that it is correct and for not providing false information.

I acknowledge that my personal and special information will be kept for the required storage and retention periods according to and in line with legislation periods applicable to the practice and the medical/healthcare industry.

In the event of a third-party request for confidential information from the practice, and if there is any doubt regarding the safety and confidentiality process, the Practice may insist on following the processes stated in the Promotion of Access to Information Act (PAIA). Requests for access to information kept by the practice can be lodged with the Information Officer of the Practice.

I acknowledge that my patient information may be disclosed by the practice in response to a specific request by a law enforcement agency, *subpoena*, court order, or as required by law.

I accept that clinical information obtained in sessions may be used in supervision sessions for the sole purpose of obtaining further professional opinion for the course or direction of psychotherapeutic treatment. At no time will any identifying information be used. The patient may object to de-identified information being used in any circumstances.

I am aware that I should communicate confidential information via Sophia Combrink's email address, sophia.combrink@gmail.com. I am aware that the cellphone number provided is for appointment and booking purposed only and is not a means to communicate with Sophia Combrink personally. I am aware that the business cellphone is not a confidential platform as reception staff have access to the phone for business purposes.

I hereby declare that I understand and accept the above contract and that the information provided is true and correct to the best of my knowledge.

Print name: _____ Signature: _____ Date: _____
