

Clinical Psychology Practice

Mark Steyn | Clinical Psychologist

Private Practice | Psycholegal Services | Corporate Consulting

Private & Confidential

Psychological Services Consent / Assent and Contract

CLIENT / PATIENT

Full Name:			
Identity No.:	Date of Birth:		
Occupation:	Employer / Organisation:		
Physical Address:			
Postal Address:			
Telephone:	(Home) (Mobile)	eMail:	
Clinical / Professional Service (please select the option that best describes your referral / reason for consultation):			
Private / Clinical Practice	<input type="checkbox"/>	Psycholegal Services <input type="checkbox"/>	Other <input type="checkbox"/>

PARENT / GUARDIAN (Client / Patient is under 14 years of age, or when factors limiting capacity to consent prevail)

Full Name:		
Identity No.:	Date of Birth:	
Occupation:	Employer / Organisation:	
Physical Address:		
Postal Address:		
Telephone:	(Home) (Mobile)	eMail:

I / We, the undersigned (herein referred to as the "Client / Patient" and / or "Parent / Guardian", as the case may be), hereby consent / assent to receiving psychological services, including but not limited to clinical and / or psychological assessment(s) and / or psychotherapy and / or counseling and / or such other related psychological service(s) (herein referred to as the "psychological service(s)") as may be provided to the Client / Patient by Mark Steyn, a Clinical Psychologist registered with the HPCSA (herein referred to as the "Practitioner"), on the following terms:

Place

Psychological services are provided on an Client / out-Patient basis at either 14 Kloof Street, Sea Point, Cape Town or at 6 Feldhausen Avenue, Claremont, Cape Town; or on an in-Patient basis at a facility to which the Client / Patient has voluntarily / involuntarily been admitted; or at such other place as may be agreed to between the Client / Patient and Practitioner.

Confidentiality and Records

Client / Patient confidentiality is maintained on a Practitioner : Client / Patient professional basis, subject to any limitations prescribed in law or by any competent authority or any process associated with medical aid, account billing, and payment collection. Professional consultations and / or discussions may be recorded in the form of clinical and / or other notes and / or audio-visual recordings, as the case may be, which will remain the professional care and responsibility of the Practitioner.

Professional Disclosure and Reporting

Disclosure to third party(ies) of confidential information is permitted when: written consent by the Client / Patient and / or Parent / Guardian is provided; for professional, supervisory, legal and statutory purposes; in the best interest of the Client / Patient or Public; and for professional or ethical reason(s) relating to risk of harm to any person(s) or property. .../ 1|2

PERSON RESPONSIBLE FOR PAYMENT OF PRACTICE FEES AND CHARGES

(if **NOT** the same as the Client / Patient and / or Parent / Guardian)

Full Name:		
Identity No.:	Date of Birth:	
Occupation:	Employer / Organisation:	
Physical Address:		
Postal Address:		
Telephone:	(Home) _____ (Mobile) _____	eMail: _____

Practice Fees and Charges

Practitioner : Client / Patient Scale

Practice fees and charges are charged at private rates on a Practitioner : Client / Patient scale and are to be settled direct with the practice. Further details about practice fee rates and charges are available at www.psydyn.com.

Medical Aid

This practice does not claim from medical aid. However, Clients / Patients are advised to claim such fees and charges from their medical aid (where applicable) themselves **AFTER** settlement of the account with the practice direct. Please note that medical aids typically provide psychology services benefits from either prescribed minimum benefits (PMB’s) or medical aid plan specific benefits and / or medical savings account (MSA’s), as the case may be. Clients / Patients are encouraged to enquire with their medical aid scheme or plan (where applicable), as to the scope, quantum, and annual limit for psychology service benefits available to them, prior to commencement of any psychology service.

Payment Responsibility

Practice fees and charges remain payable in full by the Client / Patient and / or Parent / Guardian and / or the person responsible for payment of the practice fees and charges as joint and severally liable surety(ies) and co-principal debtor(s).

Payment

All practice fees and charges are to be settled at the time of consultation, or per the service quote requirements, and remains payable in full together with interest at 15% p.a. together with any collection and / or legal fees on outstanding amounts.

Late Arrival, Non-completion, Cancellation and Rescheduling of Appointments and Services

All fees and charges are charged for in full for all appointments and services scheduled, including where a Client / Patient is late for an appointment or does not complete a particular scheduled service. Appointments that cannot be held may be rescheduled for another appointment at no extra charge provided such notice is given to the Practitioner at least 24 hours in advance. Appointment(s) that are **NOT** rescheduled at least 24 hours in advance or where a Client / Patient does **NOT** arrive for an appointment or summarily cancels and does reschedule an appointment, will be liable for a cancellation fee equal to the applicable practice fee and charges plus any administrative or other costs incurred, which shall remain payable in full by the next appointment or until settled together with charges for interest at 15% p.a. plus any collection and / or legal fees.

I / We, the undersigned, confirm and warrant that the information provided herein by me / us is true and accurate and I / we confirm that the contents of this document have been explained to me / us and that I / we understand the terms and conditions contained herein, that I / we have satisfied myself / ourselves to any questions that I / we may have relating hereto and that I / we voluntarily and give my / our consent / assent to the psychological services as contemplated herein.

For: Practitioner

For: Client / Patient / Parent / Guardian / Person Paying

SIGNATURE

Client / Patient

SIGNATURE

Parent / Guardian

SIGNATURE

Mark Steyn | Clinical Psychologist
HPCSA PS0122831 | BHF PN0573744

Person Responsible for Payment (if NOT the same as the Client / Patient and / or Parent / Guardian)

Y Y Y Y / M M / D D
DATED

Y Y Y Y / M M / D D
DATE