

Client Details and Consent Form

**Psychological Service Personal Information**

As part of providing a psychological service to you, we 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 and treatment that is conducted.

You may view and/or have a copy of the material recorded in your ﬁle upon request, subject to the exceptions in National Privacy Principle 6.

**Conﬁdentiality**

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

It is subpoenaed by a court, or

Failure to disclose the information would place you or another person at risk; or

Your prior approval has been obtained to:

- provide a written report to another previously uninvolved professional or agency.e.g. a GP or a lawyer; or

- discuss the material with another person. e.g. a parent or employer

Please note that as part of the Better Access Program, Medicare insists that psychologists write a number of reports to your GP during the course of treatment to ensure that you continue to receive a rebate and the GP remains involved in the treatment.

While email is regularly used to schedule appointments, we do not recommend you send conﬁdential information to your psychologist via email, as email is not secure, and your privacy cannot be guaranteed.

**Service provision via telehealth**

Where suitable, therapy may be provided to you by video call or phone call (collectively referred to as “telehealth”).

You are responsible for your own technology costs associated with setting yourself up to access telehealth services.

Compassionate Journey will be responsible for the cost of the call to you and the cost associated with the platform used to conduct telehealth services.

To access telehealth sessions, you will need access to a quiet, private space; an appropriate device (e.g. smartphone, computer, webcam); and a reliable broadband internet connection. Detailed information is available on our website.

The privacy of any form of communication via the internet is potentially vulnerable and limited by the security of the technology used. To support the security of your personal information, for video calls we use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hosted on our own secure servers, with end-to-end encryption.

A telehealth session may be subject to technical limitations such as an unstable network connection which may aﬀect the quality of the psychology session.

Telehealth might not be suitable for your treatment. Your psychologist will consider and discuss with you the appropriateness of ongoing telehealth sessions.

**Cancellation and Fee Policy**

If you need to cancel or postpone the appointment, please give us at least 24 hours’ notice, otherwise you may be charged the cost of the session. If Medicare or any other 3rd party refuses to pay for your session, you agree to cover the cost of the session. You agree to cover any third-party collection fees incurred.

**Limitations of service**

You acknowledge that we are not an emergency service, are not always available at short notice or outside our regular practice hours, and we may not be able to respond to telephone calls or emails requesting urgent assistance. Ask your psychologist if you wish to be provided with the details of other services who can provide these services.

NAME:

DATE OF BIRTH:

GENDER:

MEDICARE CARD NUMBER:

NUMBER NEXT TO YOUR NAME: VALID TO DATE:

ADDRESS:

EMAIL:

MOBILE PHONE:

NAME OF THE PERSON WHO OR REFERRED YOU OR RECOMMENDED THIS SERVICE:

IF THE CLIENT IS A MINOR, PLEASE PROVIDE DETAILS OF THE PARENT/GUARDIAN FILLING IN THIS FORM:

**Medical Practitioner**

NAME:

PHONE:

DATE OF LAST CONTACT:

**Previous Counsellor/therapist (if any)**

NAME:

PHONE:

DATE OF LAST CONTACT:

BRIEFLY DESCRIBE THE REASON FOR YOUR VISIT:

I have read and understood the above Consent Form. I agree to these conditions for the psychological service provided by Compassionate Journey for myself, and /or the minor(s) under my care.

YOUR SIGNATURE:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_