PATIENT DETAILS
(ADULTS/CHILDREN)
(ALL INFORMATION MUST BE COMPLETED)

Psychinc.

Surname: _____ Full names: _____
Date of birth: YYYY/MM/DD ID Number: _____
Home Language: _____
Physical address: (domicilium citandi et executandi) _____
_____ Code: _____
Postal Address: _____ Code: _____
Telephone: (h/cell) _____ (w): _____
E-mail address: _____
Marital Status: _____ Occupation: _____
Employer / School: _____
Referred by: _____
Family Doctor: _____ Tel: _____

DETAILS OF THE PERSON RESPONSIBLE FOR ACCOUNT

Surname: _____ Full names: _____
ID Number: _____
Physical address: (domicilium citandi et executandi) _____
_____ Code: _____
Postal Address: _____ Code: _____
E-mail address: _____
Occupation: _____
Employer: _____
Work address: (street address) _____
_____ Code: _____
Telephone: (h/cell) _____ (w) _____

FULL DETAILS OF MEDICAL AID SCHEME

Med. Aid Name: _____ Med. Aid Number: _____
Main Member: _____ Dependent Code: _____
Med. Aid Option: _____ ID Number: _____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY

Surname: _____ Full names: _____
Relationship: _____ Telephone:(w) _____ (h/cell) _____

1. I accept that accounts are payable within 30 days after rendering of the account and that interest at the rate of 6 % per month will be levied after 60 days on all amounts in arrears, calculated from date of the first rendered account.
2. Where possible accounts will be claimed directly from medical aids. If you want a copy of your account please request it from the administration staff.
3. I accept that if I do not cancel appointments 24 hours in advance, a 60-minute consultation fee will be levied.
4. Services rendered including assessments, reports, telephone and any other action(s) performed as part of case management will be charged in accordance to the tariffs (rates).
5. Please note, all cash clients, if cash is not paid or EFT is not made immediately after consultation, medical aid rates will be applicable in accordance with the tariffs (rates).
6. I undertake to notify my psychologist's secretary/receptionist, as to any changes of information given herein by myself immediately or within 30 days.
7. I agree that all telephonic and/or virtual consultations will be charged at normal rates.
8. On-site consultations at hospitals, schools, retirement homes, and home visits in any emergency charged plus 50% of the consultation fee.
9. After hours (before 8:00 and after 17:00, weekends (Saturdays and Sundays) and public holidays (Stipulated in the South African calendar) sessions are charged plus 30% of the consultation fee.
10. I accept that it is my responsibility to determine what amount is paid by my medical aid, including limits payable per session and in total per annum. I am personally responsible for any amounts not covered by my medical aid, whatever the reason. I confirm that I will remain responsible for payment of any services rendered to myself as patient despite the fact that I do have a medical aid or that a third party has taken responsibility for this account.
11. Should legal action be necessary to recover any amounts in arrears, I, or the person accepting liability for the payment of this account as provided for in clause 6 above, shall be liable for the payment of all legal costs incurred on an Attorney-and-Client scale, including collection fees, tracing fees, revenue stamps, sheriffs fees and VAT (on the applicable scale). Abovementioned Attorney-and-Client scale will include taking instructions and the issuing of a letter of demand.
12. I chose as my domicilium citande et executandi, the physical residential address as stated on the counter side hereof.
13. I agree and hereby consent that a credit check may be done on my creditworthiness at a credit bureau.
14. I agree to the jurisdiction of the Magistrate's Court, irrespective of the amount of the claim against me, or by choice of the Plaintiff to the jurisdiction of the Supreme Court, Gauteng Division of South Africa.
15. I accept confidentiality is kept except: if I sign consent for information to be released; if the life or safety of myself or others is threatened; if child abuse/neglect is suspected; if the law requires it by court order; for case management purposes and administration.
16. Medical aids often request a diagnosis and treatment progress reports. Permission is granted to contact any relevant third parties concerning my treatment. This includes but is not limited to family members, medical doctors, teachers, previous psychologists, psychiatrists and insurance companies. I hereby give my consent to obtaining and/or sharing my personal information in accordance with POPI Act.
17. Permission is given / not given for necessary video/audio taping of sessions (delete what you don't agree to).
18. By signing this, I agree to the use of Telemedicine where necessary.
19. I give permission / do not give permission (delete what you don't agree to) for my data to be used for research purposes. Anonymity will be maintained.
20. Psychinc's (a Division of Wellifehub Inc, formerly Pretoria Psychologists (Pty) Ltd) privacy policy is in line with POPIA and are committed to ensuring the safety of your personal information. A copy of our privacy policy and details of our information officer is available on request.
21. If there is reasonable reason to think I may endanger myself or others, the person I have listed for emergencies may be contacted.

I acknowledge that I have read the above conditions, that I fully understand the meaning thereof and accept same.

Signature: _____

Full name: _____ Date: YYYY/MM/DD