JENNA KILIAN
CLINICAL PSYCHOLOGIST

Physical & Postal Address:
311 Kingsway Avenue,
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MSc. Clinical Psychology (U.L)
Pr. No.: 0588067
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CHILD'S DETAILS

By providing the information below you consent to this information being kept and processed for the purposes of providing treatment and for this information to be used to contact you when necessary. You also agree to notify me of any changes / updates to the information provided below.

Surname:	First Name(s):
ID Number:	Age:
School:	Grade:

PARENT'S DETAILS

By providing the information below, you confirm that you have obtained consent from the person/s listed to provide their contact details. You consent to this information being kept and processed for the purposes of providing treatment and for this information to be used to contact you when necessary. You also agree to notify me of any changes / updates to the information provided below. The below-mentioned residential address is the Domicilium et Cititandi et Executandi for all purposes of this agreement and at law.

PARENT: Biological mother □ Biological father □ Legal Guardian □ Other □

Surname:	First Name(s):
ID Number:	Occupation and Employer:
Residential Address:	Cell No.: Alternate No.:

PARENT: Biological mother □ Biological father □ Legal Guardian □ Other □

Surname:	First Name(s):
ID Number:	Occupation and Employer:
Residential Address:	Cell No.: Alternate No.:

PRINCIPLE MEMBER OF MEDICAL AID / PERSON RESPONSIBLE FOR ACCOUNT'S DETAILS

By providing the information below, you confirm that you have obtained consent from the person listed to provide their contact details as the person who will be responsible for payment of your account. You also consent to this information being kept and processed for the purposes of obtaining payment. You also agree to notify me of any changes / updates to the information provided below. **Please note that statements and invoices will be sent to the principle member or the person responsible for the account – please ensure the contact details below are those details you would like payment information to be sent to.** A copy of your medical aid card, your ID document and the main member's ID document will be requested.

Surname:	First Name(s):
ID Number:	Email:
Cell No.: Alternate No.:	Residential Address:

- If both biological parents are not attending the first intake session together, the other biological parent has knowledge of your visit to this practice and has consented to their child being seen for psychotherapy: **YES □ NO □ Initial _____** (if NO, written consent has to be received by the un-accompanying parent before the child is seen.)
- If the parent bringing the child is not the main member of the medical aid then the main member has knowledge of your visit to this practice and has consented to the medical aid being used in this regard: **YES □ NO □ Initial _____** (if NO, then you are responsible for payment privately before the session begins - medical aid cannot be used.)
- I hereby give Jenna Kilian consent to claim from my medical aid and to use relevant ICD-10 codes when doing so **YES □ NO □ Initial _____**

NEXT OF KIN, EMERGENCY CONTACT (A close relative / Friend)

By providing the information below, you confirm that you have obtained consent from the person listed to provide their contact details as the person who will be contacted in the case of emergencies or when the practice is unable to get hold of you or the person responsible for the account. You also consent to this information being kept and processed for the purposes of emergencies and in order to get into contact with you when necessary. You also agree to notify me of any changes / updates to the information provided below. **Please note this contact will also be contacted in cases of risk if a parent cannot be reached (see limits to confidentiality).**

Surname:	First Name(s)
Relation to client:	Cell No.: Alternate No.:

HOW DID YOU HEAR ABOUT THE PRACTICE?

Circle: Doctor / Health Professional / Word of mouth / Website / Billboard / Other :
Did you receive a referral letter:
Does the health professional require feedback?:

- **Risks and benefits:**

  Therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration etc. because the process of therapy involves discussing unpleasant aspects of your life. However, therapy has been shown to have benefits, these include personal awareness, insight for managing stress and resolutions to specific problems. Therapy requires active effort on your and your child's part. By signing this document, you provide consent for you and your child to voluntarily undergo psychotherapy.

- **Child therapy for children under the age of 12 years.**

  Parents are seen without the child for the initial session in order for background information as well as current presenting complaint information to be worked through. Your child will then be seen for between 2 to 5 sessions after that alone for therapy where I will be getting to know him/her, establishing a rapport, gaining information regarding their difficulties and using psychotherapeutic interventions along the way – this is done by playing games, drawing, talking, questionnaires etc. Feedback / parental counselling will then be given to both parents – further sessions will take place thereafter as parents and therapists see fit.

- **Limits of confidentiality:**

  Records relating to your child's therapy are kept locked and are not available to anyone besides myself. Information relating to your family's appointments, medical aid and for billing purposes etc. are available to my receptionist and practice managers. The law places certain limits on confidentiality and they include the following, when: i) The client is a danger to themselves or others; ii) there is suspicion of the abuse of a child, adult or vulnerable person; iii) ordered by the court. More specifically should you or your child be a risk to yourself/themselves or one another or others and admission is refused at a psychiatric facility, the person responsible for the account, the authorities or next of kin will automatically be informed of this risk. Relevant information or feedback to your GP, Psychiatrist or other medical specialist or referring party will be given to maximise treatment. Be aware that all sick notes etc. require medical diagnostic information and this may compromise your confidentiality. Unidentifiable clinical information about yourself may be used for retrospective research record review, professional consultation and supervision purposes. The practice cell phone is managed by my receptionist and not myself – please keep this in mind in terms of information shared via calls, WhatsApps, smses etc regarding your confidentiality. Bumping into each other outside the practice may take place, I will follow your lead as to how you would like to respond in this situation (i.e. greet or avoid one another). Your child is still a minor therefore relevant feedback can be given to you, as their parents or guardians. This information is still first discussed with your child and verbal consent will be asked of them to share information that has been discussed in the sessions. Relevant and risk-related information will be given as feedback ONLY.

- **Appointments:**

  Appointments are generally 50-55 min in duration. This practice sends out courtesy reminders via SMS, WhatsApp or Email, however, it remains the sole responsibility of the client to arrive at their session on time. Late arrival at your appointment will decrease the length of your session and you are still charged for the full session fee. Appointments not kept or cancelled with less than 24hrs are discouraged as it does not give the practice enough time to contact other clients on my waiting list to fill your appointment slot. The number of sessions you will need will be dependent on the psychologist's discretion, availability of time as well as your effort placed into the process. You are welcome to terminate therapy at any point. No legal, forensic, employment, academic etc. reports, notes, letters etc. will be written for any reasons as sessions are **only therapeutic** and not forensic/ psycho-legal / medico-legal, assessment etc. in nature.

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- **Fees and non-payment of fees:**
  - This practice charges medical aid rates which are different for each medical aid. These rates may be given to you on your request. The main member/client remains at all times responsible for payment of accounts even if insured with a medical aid. It is the client's responsibility to ensure that they have adequate funds available. Some medical aids require a doctor's referral letter - the onus is on the client to obtain this when necessary. Diagnostic information (ICD-10) information has to be provided to medical aids for claims to be processed - failure to do so leads to claims being rejected. Please note that submitting diagnostic information may compromise confidentiality - please advise this practice should you not want the diagnostic code disclosed. By signing this agreement you agree that I may provide relevant information to your medical aid.
  - You are welcome to pay privately as well at a rate of R850 for each session. The amount needs to be paid in cash, card, Zapper or via EFT prior to or on the day of each session. The practice will not run any accounts. Diagnostic information (ICD-10) information will be added to your statement - please advise this practice should you not want the diagnostic code disclosed. By signing this agreement you agree that I may make use of an ICD-10 code.
  - Accounts overdue by 30+ days will be handed over to an attorney or credit bureau for collection without further notice being given. The main member/client is liable for all costs incurred.
- **Contacting me:**

  Kindly contact my office 073 950 3638 for all appointments and queries. In the event of an emergency (life-threatening) you may request for me to contact you during office hours, however, if I am unavailable or you require assistance after hours, the client agrees to go to the nearest hospital, contact their GP or book an emergency consultation for the following day. Please avoid telephone consultations, emails, WhatsApp or SMS messages related to therapy – this may compromise your confidentiality. You will be billed in this regard for telephonic consultations/assistance and for the perusal of emails/documents as per the duration thereof. Due to the nature of my work I am unable to accept any current/past client invitations on all social media platforms or consult with any person I am in contact with on a personal level or consult with you if I am already seeing your family member / close relation (please declare, if you are aware this is the case, at your initial session). No consulting will be available on Saturdays (unless booked), Sundays, public holidays and/or after hours (before 08:00 or after 16:00). Should you have any information which you would like to share with me, please ask to discuss this with me for the first 5-10 minutes in your child's next booked session.
- **Communication with Clients:**

  This practice uses the following methods of communicating information regarding appointments, billing etc: SMS; Email; WhatsApp; Telephone / cellphone. Please advise us if you do not wish us to use a particular media.

I have read and understood the above contract and accept all conditions thereof and acknowledge that by signing this contract I am legally bound by the provisions thereof:

_____ _____

Parent's Signature **Parent's Signature**

_____ _____

Principal Member's Signature **Date**