JENNA KILIAN
CLINICAL PSYCHOLOGIST

Physical & Postal Address:
311 Kingsway Avenue,
Amanzimtoti,
4126

MSc. Clinical Psychology (U.L)
Pr. No.: 0588067
HPCSA No.: PS 012 4877

Tel. No.: 073 950 3638
jenna@jkclinicalpsychologist.co.za
www.jkclinicalpsychologist.co.za

OVER 12 YEARS OLD

CLIENT'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 you have come alone, your parents or guardians are aware of your visit to the practice: **YES □ NO □ Initial _____** (if NO, please take note of limits to confidentiality on the following page and regarding where payment details are sent to).
- If you or the parent bringing you 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 or the person bringing you is 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 part. By signing this document, you provide consent for you to voluntarily undergo psychotherapy.
- **Child therapy for children over the age of 12 years.**

  Parents are welcome to be seen for the first 10 to 15 minutes of the very first session, should their child consent to this, in order for your parents to share information regarding their concerns for you and for the therapist to get a better understanding of your family. Thereafter, parents will only be brought in if you are at risk to hurting or killing yourself or others (see limits to confidentiality) or if it would be beneficial for them to attend a feedback or parental counselling session in order to assist you better in your process to mental health – you and I will discuss what will be shared and you will provide consent to relevant information being disclosed to your parents. Parents / guardians, if you would like to give me information during this process, please note that all information shared with me will be discussed with your child – therapy involves openness and transparency – so please bare this in mind in terms of what you share.
- **Limits of confidentiality:**

  Records relating to your 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 be a risk to yourself or others and admission is refused at a psychiatric facility, your parents, 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 (e.g. school) will be given to maximise treatment when necessary. 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). You are of the age that relevant feedback can be given to your parent or guardian at your request – it may be at times suggested by the therapist if she feels that it would help reduce your mental health difficulties. This information is still first discussed with you and consent will be asked of you to share information that has been discussed in the sessions (barring risk). Relevant and risk-related information will be given as feedback ONLY. If you are attending therapy without your family's knowledge but are using medical aid paid by them or if they are being billed for the session – feedback in terms of how many sessions are needed and current progress may need to be given to them at their request.
- **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

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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.

- **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 or parent/guardian 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 your parents/guardians 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:

_____	_____	_____
Client's Signature	**Parent's Signature** **Mother / father / guardian**	**Parent's Signature** **Mother / father / guardian**
_____	_____	
Principal Member's Signature	**Date**	