



REFERRING PRACTITIONER (if applicable)			
REFERRING PRACTITIONER:	SCOPE OF PRACTICE: (e.g. Psychology; OT)	PRACTICE NUMBER:	
1. MINOR PATIENT INFORMATION (PATIENT UNDER 18 YEARS)			
SURNAME:	FULL NAMES:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	<input type="checkbox"/> Miss <input type="checkbox"/> Prof. <input type="checkbox"/> Mx.
IDENTIFICATION NUMBER:	BIRTH DATE:	GENDER:	
HOME LANGUAGE:	RESIDENTIAL ADDRESS:		
WITH WHOM DOES THE MINOR RESIDE:			
PAYMENT METHOD: (for accurate record-keeping)		IF CLAIM IS TO BE SENT TO THE MEDICAL AID:	
CASH: <input type="checkbox"/> CARD: <input type="checkbox"/> LAST 4 DIGITS OF CARD: _____		MEDICAL AID DEPENDENT CODE: _____	
CURRENT SCHOOL GRADE:	SCHOOL NAME:		
SCHOOL CONTACT DETAILS: <i>(We will only contact your child's school/teacher for therapeutic purposes. Information will only be provided to a specific person nominated by you at the school, with your written consent.)</i>	<div> _____ _____ </div>		
2. MOTHER / GUARDIAN / CAREGIVER			
(please note that as we are unable to verify agreements between parents / caregivers, the adult who brought the child for healthcare will be liable for the account if the medical scheme does not pay, or does not pay for the care in full)			
SURNAME:	FULL NAMES:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	<input type="checkbox"/> Miss <input type="checkbox"/> Prof. <input type="checkbox"/> Mx.
IDENTIFICATION NUMBER:	BIRTH DATE:	GENDER:	
HOME LANGUAGE:	E-MAIL ADDRESS:	2 ND E-MAIL ADDRESS: (if applicable)	
POSTAL ADDRESS:		RESIDENTIAL ADDRESS: (if different from Postal Address)	
HOME :	WORK :	MOBILE :	
MEDICAL AID:	MEDICAL AID PLAN:	MEDICAL AID #:	



OCCUPATION:	EMPLOYER NAME:	
EMPLOYER CONTACT DETAILS: <i>(We will only contact your employer if we are unable to reach you for account purposes. Healthcare information will only be provided to a specific person nominated by you at your employer, with your written consent.)</i>	_____	_____
FAMILY / FRIEND CONTACT DETAILS: <i>(for account purposes should we be unable to contact you)</i>	_____	_____
NAME: _____		
I hereby accept that – E-mail <input type="checkbox"/> YES <input type="checkbox"/> NO and/or SMS <input type="checkbox"/> YES <input type="checkbox"/> NO and/or Whatsapp <input type="checkbox"/> YES <input type="checkbox"/> NO messages may be sent to me in order to confirm appointment and convey general information of the practice and my child's healthcare, if child is younger than 12 years or older than and have agreed to me, the parent/caregiver/guardian receiving the information.		

2. FATHER / GUARDIAN / CAREGIVER (please note that as we are unable to verify agreements between parents / caregivers, the adult who brought the child for healthcare will be liable for the account if the medical scheme does not pay, or does not pay for the care in full)		
SURNAME:	FULL NAMES:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.
		<input type="checkbox"/> Miss <input type="checkbox"/> Prof. <input type="checkbox"/> MX.
IDENTIFICATION NUMBER:	BIRTH DATE:	GENDER:
	/ /	
HOME LANGUAGE:	E-MAIL ADDRESS:	2 ND E-MAIL ADDRESS: (if applicable)
POSTAL ADDRESS:	RESIDENTIAL ADDRESS: (if different from Postal Address)	
HOME :	WORK :	MOBILE :
MEDICAL AID:	MEDICAL AID PLAN:	MEDICAL AID #:
OCCUPATION:	EMPLOYER NAME:	
EMPLOYER CONTACT DETAILS: <i>(We will only contact your employer if we are unable to reach you for account purposes. Healthcare information will only be provided to a specific person nominated by you at your employer, with your written consent.)</i>	_____	_____
FAMILY / FRIEND CONTACT DETAILS: <i>(for account purposes should we be unable to contact you)</i>	_____	_____
NAME: _____		
I hereby accept that – E-mail <input type="checkbox"/> YES <input type="checkbox"/> NO and/or SMS <input type="checkbox"/> YES <input type="checkbox"/> NO and/or Whatsapp <input type="checkbox"/> YES <input type="checkbox"/> NO messages may be sent to me in order to confirm appointment and convey general information of the practice and my child's healthcare, if child is younger than 12 years or older than and have agreed to me, the parent/caregiver/guardian receiving the information.		

TERMS & CONDITIONS OF THE PRACTICE

I, the undersigned, confirm that:

1. The above information is true to the best of my knowledge
2. That I have the consent of a family member/friend and my employer to disclose their contact details
3. Where I, the patient, am not the Main Member, I have the consent of the Main Member to disclose his/her details for account administration
4. That the patient (dependent) or main member is primarily responsible for payments of accounts for services rendered
5. Medical schemes differ regarding benefits for services rendered, and that it is the responsibility of the patient or main member to contact the medical scheme prior to appointment/admission to confirm any specific stipulations
6. **I acknowledge and accept, in the event that the Medical Aid does not provide coverage, that I am personally responsible for settling my account**
7. Appointments must be cancelled within 24 hours and failing to do so will result in the full consultation fee being charged
8. I am aware of my rights under the POPI Act, including my right to refuse to consent to marketing and to refuse disclosures - unless required by a law, and to change or remove information, where possible
9. The accompanying "**Patient Information Document**" has been read and that I as the patient am bound to the content thereof and that I have had an opportunity to ask questions on aspects thereof that I was not certain about
10. I acknowledge and agree to raise any concern surrounding treatment directly with Dr de Villiers so that therapeutic goals can be reached and concerns can be addressed
11. I understand that while Dr. Leonora de Villiers will provide services to the best of her professional ability, specific results cannot be guaranteed. If I have any concerns about my therapy, I will first discuss them directly with Dr. de Villiers so that we can work together to address them. I agree that, provided services are delivered competently and in line with professional standards, I will not pursue legal action based solely on an unexpected or unsatisfactory outcome
12. The Account Holder, surety or legal guardian hereby consents to the disclosure and exchange of personal financial information to a credit bureau or financial institution in accordance with the National Credit Act

Information about you cannot be exchanged without your consent. Your signature on this release authorises This Practice to obtain and release personal information regarding your care in accordance with PAIA and POPIA Compliance.

Personal & Special Personal Information is collected, stored & shared by This Practice for the following reasons (for a more comprehensive description of all records held at The Practice as well as policies implemented by The Practice, please contact The Practice Information Officer for a copy of the PAIA Manual as well as the POPIA Compliance Manual.

PURPOSE: For the holistic treatment of you as the patient; For the administration of your patient treatment and the practice; For the performance of duties in terms of any agreement between yourself and the practice; Administrate your accounts and manage any application, agreement, or correspondence that you may have with The Practice; Any other reasonably required purpose relating to The Practice.

Please note, that this practice is administrated by **PSYBASE PRACTICE MANAGEMENT BUREAU** (operator) and as a result, the following information is disclosed for administrative purposes: Client/patient contact and medical aid details, ICD-10 codes, correspondence and Consultation dates and procedures.

☐ I accept this authorization

☐ I do not accept this authorization in the event you choose to keep all information confidential, please note that the payment for all services rendered will be payable on date of service, as the administration process cannot continue)

1. _____
Name of adult who brought the child in for healthcare services

Signature

2. _____
Mother/Guardian/Caregiver Name Signature

3. _____
Father/Guardian/Caregiver Name Signature

Signed at: _____ / ____ / 20____



This practice is administrated by:

PSYBASE SOFTWARE
Supporting the heart & soul of the health industry