Vicky Fabricius
Counselling Psychologist

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Sea Point
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Partner 1 Personal Details

Name and surname _____
Tel _____
Cell _____
Email _____
Postal address _____
Date of birth _____
ID Number _____
Relationship to main member _____
Medications used _____

Partner 2 Personal Details

Name and surname _____
Tel _____
Cell _____
Email _____
Postal address _____
Date of birth _____
ID Number _____
Relationship to main member _____
Medications used _____

Medical Aid Details

Medical aid _____
Medical aid number _____
Medical plan _____

Main Member Personal Details

Name and surname _____
Tel _____
Cell _____
Email _____
Postal address _____
Date of birth _____
ID Number _____

Psychological Services Information (PLEASE READ CAREFULLY)

Confidentiality
By law, psychological services are confidential. I need your permission to discuss your case with anyone else. However, there are some limits to confidentiality: I may be required to discuss your case without your permission under some exceptional circumstances. Such circumstances include, but are not limited to:

- being ordered to disclose information in a court of law
- emergency situations which might place you or others in danger
- mental health emergencies requiring urgent intervention
- circumstances which psychologists are required to report by law (eg. evidence of child abuse or fraud)
- circumstances where you have given your psychologist consent to release information to specific persons for specific purposes
- supervision with other psychologists

Medical aids
Most medical aid schemes require a diagnosis before they will reimburse for services. If you do not want me to state an accurate diagnosis on your accounts, please discuss this with me.

Fees
My fees are in keeping with medical aid rates. I charge R850 for a couple session. **My rates increase on an annual basis**.

Undertaking
I, _____ (Your full name), hereby agree that:

I, _____(Your full name), hereby agree that:

1. I understand and accept the terms of the contract and that all the information I disclosed in this document is correct and true.
2. I am liable for all costs including legal and debt collection costs should it arise due to unpaid accounts.
3. I am solely responsible for the payment of the account regardless of having a medical aid or any other fund.
4. It is my responsibility to ensure that all accounts are paid by the stipulated date. No reports will be released if the accounts are not paid in full.
5. **In the event of a cancellation I should provide 48 hours notice in advance otherwise I will be liable for full payment of the service being provided.**

Your signature below indicates that you have read the information in this document, that you have understood it and that you agree to abide by its terms for as long as you are my patient.

Signature _____ Signature _____

Date _____ Date _____