Melissa Roos

Kliniese Sielkundige | Clinical Psychologist

MSc (Kliniese Sielkunde) (NWU)

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CLIENT INFORMATION

Initial(s):	Full name(s):
Surname:	ID:
Cell:	DOB (mm/dd/yyyy) :

MAIN MEMBER OF MEDICAL FUND/ PERSON RESPONSIBLE FOR THE ACCOUNT

Title:	ID:
Full names(s):	Surname:
Postal Address:	Residential Address:
Code:	Code:
Cell:	Employer:
Email:	Occupation:

MEDICAL AID DETAILS

Medical Aid Name:	Option / Plan :
Medical Aid Number:	Dependant Code :
Main Member ID:	

CONTACT DETAILS OF OTHER PARENT (IN CASE Of MINOR CLIENT)

Name:	Surname:
Cell:	Email:

PSYCHOLOGICAL SERVICES ARE RENDERED SUBJECT TO THE FOLLOWING CONDITIONS

1. Appointments not cancelled 24 hours in advance will be charged a cancellation fee of R500.
2. Services are charged for according to Medical Aid rates. All accounts are payable strictly within 30 days from the date of the account. After 90 days accounts will be handed over for debt collection.
3. This practice is contracted into most medical aids and charge according to the national reference price list and the BHF tariffs for psychologists that will adjust annually.
4. The undersigned understands that claims submitted to a medical aid require an ICD 10 or diagnoses code. The undersigned thus gives permission to disclose an ICD 10 diagnoses code on the account.
5. In the event of divorced or minor client, the person signing this agreement remains personally liable for the payment of the account, even in cases where the previous spouse or parent is liable for the payment of medical expenses. A letter of consent for the consultation must accompany the client.
6. Personal particulars are voluntarily disclosed by the client and will form part of the permanent confidential file, which will remain the property of the practice.

I, the undersigned, personally accept responsibility to see to the payment of the account, as well as to abide by the above-mentioned conditions.

Full Names and Surname:	
Signature:	Date: