NIC HAZELL
CLINICAL PSYCHOLOGIST
Practice # 0591920 HPCSA# 0125024

Room 105
Library Square
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Claremont
Cape Town

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PSYCHOLOGICAL SERVICES CONSENT / ASSENT AND TERMS & CONDITIONS

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.

CLIENT'S DETAILS – to be completed by client or person accompanying a minor

First Name: ..... Surname: ..... Title: ..... Initials: .....

Date of birth: ..... Age: ..... Identity No: .....

Tel: H..... W..... Cell..... E-mail : .....

Home address:.....

Occupation/School: ..... Employer: .....

If couples / family therapy - name of second client:

First Name: ..... Surname: ..... Title: ..... Initials: .....

Date of birth: ..... Age: ..... Identity No: .....

Tel: H..... W..... Cell.....E-mail : .....

Contact person (and relationship) in case of emergency: .....

Telephone number of contact person: .....

By providing the information above, 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. You also agree to notify me of any changes to this emergency contact information.

How did you come to hear of me: If referred, who referred you?.....

▫ My Website ▫ Therapists Directory ▫ Psychotherapy.co.za ▫ Referred ▫ Other (please specify) .....

PERSON RESPONSIBLE FOR THE ACCOUNT: (if different from above)

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 agree to notify me of any changes/updates to the information provided.

First Name: ..... Surname: ..... Title: ..... Initials: .....

Identity No: ..... Relationship to client: .....

Physical address:.....

Tel: H..... W..... Cell..... E-Mail: .....

MEDICAL AID DETAILS:

Medical aid: ..... Plan: ..... Member No: .....

Name of Principal Member: ..... Dependant No: .....

I hereby consent to the provision of psychological services, including but not limited to clinical and/or psychological assessment(s) and/or psychotherapy and/or counselling and/or such other psychological service(s) as may be provided by Nic Hazell, a Clinical Psychologist registered with the HPCSA, on the following terms and conditions:

PLACE

Psychological services are provided **in-person** at Room 105, Library Square, Wilderness Road, Claremont, Cape Town, or on an in-patient basis at a facility to which the Client has been admitted, or at such other place as agreed to between the Client / Patient and / or Parent / Guardian and the Practitioner; or **electronically** and / or **virtually** on a Client / out-Patient / in-Patient basis via mediums such as email, sms, communication apps, telephone, or videoconferencing platforms.

CONFIDENTIALITY AND RECORDS

Client / Patient confidentiality is maintained on a Practitioner: Client professional basis in accordance with any applicable legislation and / or professional guidelines, including POPIA. Consultations and/or communications may be recorded in the form of clinical and/or other notes and/or recordings, and remain the professional responsibility and property of the Practitioner. The Practitioner may obtain and/or disclose any relevant confidential information to/or from any third party in accordance with any prescription or limitation in law; through a directive by a competent authority; for clinical, collateral, supervisory, legal and professional purposes; for any ethical reason; for any reason relating to risk of harm or damage to any person(s) or property; when in the best interests of the Client or Public; for related health insurance, account billing, and payment collection processes; and with the consent of the Client and/or Parent/Guardian. The Practitioner's Privacy Policy is available on request, or on the website at https://www.nichazell.com/. The Practitioner's services exclude any and all forensic and legal processes.

ELECTRONIC COMMUNICATIONS, VIRTUAL CONSULTATIONS AND TELEHEALTH PRACTICES

Scope
The facilitation of psychological services using electronic and / or virtual media such as email, sms, communication apps, telephone, or videoconferencing platforms, etc. (herein referred to as "telehealth practice/s") is a convenient means to augment the provision of in-person psychological services.

Limitations
Although telehealth practices may be convenient they offer a limited relational experience, and are not conducive to assisting Clients who are struggling with severe clinical disorders, who may be suicidal or homicidal, or who are in crisis or may be experiencing an emergency – in such situations, Clients are required to arrange an in-person consultation with the Practitioner or to contact their General Practitioner, Psychiatrist, or nearest emergency facility or helpline. Telehealth practices rely on third party technology providers and carry the risk of technical failures, distractions and interruptions, and have risks to privacy and confidentiality due to transmission and data disruptions and distortions, or interceptions by unauthorised third parties. Whilst the Practitioner undertakes to use generally acceptable standards to protect the transmission and data from any telehealth practices, no guarantees are made or implied by the Practitioner in respect of the protection of such transmission/s and data.

Requirements for Virtual Consultations
Virtual consultations require a reliable connection via an electronic device (such as a smartphone, iPad, laptop, or desktop computer) to the internet which should be secure and private, capable of a minimum speed of 4Mbps, of facilitating data transmission of up to 1GB per 45 minute consultation, and may require Clients to download software to their electronic device. Clients are encouraged to ensure the protection of transmission and data from or on their electronic devices by using reputable third party service providers and tools, such as password protection and antivirus software. A private physical environment is also required when engaging in any virtual consultation.

FINANCIAL TERMS | CONDITIONS | RESPONSIBILITIES

Practice Fees | Payment Terms | Responsibility for Payment
Practice fees remain the full responsibility of the Client and/or the person responsible for payment at all times, and are charged at either private rates on a Practitioner: Client scale or at Medical Aid Contract rates if submitted to a Medical Aid. Accounts are payable at the time of consultation by Cash or SnapScan payment, or within 3 business days of receiving the invoice when paying by Bank Deposit or EFT. The contracted private fee is R1220 per 50-minute session. Rates will increase yearly in accordance with medical aid rates. Outstanding accounts remain payable in full together with any administration and collection/legal fees by the Client and/or the person responsible for payment as joint and severally liable surety(ies) and co-principal debtor(s). The Practitioner outsources the billing administration to PsyAdmin, and all invoices, statements, collections, or other queries of a financial nature will be addressed by PsyAdmin. Note that using your name as payment reference will reflect on practice bank statements and payment notification emails/SMS

*** Late-Arrival | Non-Arrival | Cancellation of Appointments**
In the event of a Client / Patient arriving late, not arriving, or where the appointment is terminated early, the **full consultation rate** will remain payable. Cancelled appointments where a minimum of 24 hours advance notice has not been provided, will attract a cancellation fee equivalent to the normal full rate. If on medical aid, such fees will be invoiced for the Client's personal account.

Virtual Consultations
All of the above applies equally to virtual consultations, but where a virtual consultation cannot be completed due to technical reasons within the first 15 minutes of the consultation start time, the consultation will be rescheduled without charge.

Medical Aid
Clients are to enquire themselves and in advance with their Medical Aid Scheme to determine the scope of psychology services benefits available to them, as some medical aid options may not fund certain in-person and / or telehealth consultations and psychological services. The practice does not warrant the scope and quantum of benefits available under any medical aid and the Client and/or Parent/Guardian and/or the person responsible for payment remains responsible for payment of the account.

SIGNATORIES

I / We, the undersigned, confirm and warrant that the information provided herein by me/us is true and accurate and I/we confirm that the contents of this document have been explained to me/us and that I/we understand the terms and conditions contained herein, that I/we have satisfied myself/ourselves to any questions that I/we may have relating hereto and that I/we voluntarily give my/our consent/assent to the psychological services as contemplated herein.

_____ _____
Client/Parent/Guardian SIGNATURE Date

_____ _____
2nd Parent in case of a Minor SIGNATURE Date

_____ _____
Person Responsible for Payment SIGNATURE Date