Andrée Evans
Counselling Psychologist
1396 Peninsula Clinic
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NEW CLIENT FORM (Child)

Date:.....

Child Information

First Name: ..... Surname: .....

Date of Birth: ...../...../..... Age:..... Gender: ❑Male ❑Female

Year Level:..... Classroom Teacher:.....

Parents Names:.....

Email:.....

Phone Number: Home:.....Mobile: .....

Phone Number: .....Mobile: .....

Address:..... Postcode: .....

Medicare Number: ..... Child's Position on Card: .....

Payer Details:

Name: .....

Date of Birth: ...../...../.....

Medicare Number: ..... Position on Card: .....

Address: ..... Post Code: .....

Emergency Contact

❑Parents as above

or

Name: ..... Contact Number: .....

Relationship to Child:.....

Referring Doctor

Name: .....Phone Number:.....

Clinic Name & Address: .....

Doctor's Medicare Provider Number: ..... Date of Referral:.....

Referral: .....

Please complete both sides of this form.

PARENT CONSENT FORM

As part of providing a counselling service for your child, the psychologist will need to collect and record personal information that is relevant to their situation. This information will be a necessary part of the assessment and treatment that is conducted.

ACCESS

You may access the material recorded in your file upon request, subject to the exemptions in National Privacy Principle 6.

CONFIDENTIALITY

All personal information gathered by the psychologist during the provision of the counselling service will remain confidential and secure except when:

1. It is subpoenaed by a court; or
2. Failure to disclose the information would place you or another person at risk; or
3. Your prior approval has been obtained to:
    a) Provide a written report to another professional or agency, eg. a GP or a lawyer; or
    b) Discuss the material with another person, eg a parent or employer.

If a third party such as TAC, Workcover etc, fund your consultations; it may be necessary to provide reports to that funding organisation.

CANCELLATION POLICY

If you need to cancel or postpone the appointment, please give at least 24 hours' notice. If you fail to attend your scheduled counselling session without notifying us, a fee may be charged.

CONSENT

I hearby give my permission for information regarding my child's counselling progress to be exchanged with my Doctor where applicable. I understand that the counselling sessions will be otherwise confidential but if the counsellor is concerned about the safety of my child or the safety of others then confidentiality may be waived as required by the Law.

Name of Child: .....

I, (Parent / Guardian) ....., have read and understood this Consent Form. I agree to these conditions listed on this page including the confidentiality waiver.

Signature:..... Date: .....

Please note: if after reading this page you are at all unsure of what is written, please discuss it with your psychologist.