



Marinda Reynecke

☎ 012 995 4361

☎ 071 602 4408

info@therapistbox.co.za

www.therapistbox.co.za

HPCSA no - PS 0068586 | Practice no - PR 0309761

Intercare - Woodhill | Parkview Shopping Mall | Garsfontein Rd | Pretoria East

Contract with Marinda Reynecke and welcome to my practice

★ Please take your time to read and fill in this questionnaire before we commence ★

This questionnaire and subsequent therapy are regarded as strictly confidential unless you are deemed to be a danger to yourself, myself or anyone else. In such a case, confidentiality may be breached at my discretion.

Patient Details

Name:

Surname:

Identity Number:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Gender:

<input type="checkbox"/> M	<input type="checkbox"/> F
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Age:

<input type="text"/>	<input type="text"/>
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Marital Status:

Singe

Married

Divorced

Contact numbers:

(c)

(h)

E-mail address:

Currently employed?

Yes

No

Occupation:

Company Name:

Work Tel No:

Work Address:

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

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EMAIL marinda.reynecke@intercare.co.za



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Postal Address:	
	Postal Code

Home Address:	

Medical Information

Main Member Information

Name:	
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Surname:	
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Identity Number:	Gender:	Age:																			
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M	F																				

Marital Status:	Singe <input type="checkbox"/>	Married <input type="checkbox"/>	Divorced <input type="checkbox"/>
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Contact numbers:	(c)	(h)
-------------------------	-----	-----

E-mail address:	
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Medical Scheme Name:	
Member Number:	
Medical Plan:	
Dependent Number:	



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Patient Information

Dependent no:	
Referred to this practice by:	
Telephone Number of person who referred patient:	

Are you on any Medication? If yes, please specify:

Next of Kin

Name:		
Surname:		
Contact numbers:	(c)	(h)
E-mail address:		

Contact telephone numbers of two friends who are not immediate family:

★ People that can be contacted in the case of an emergency ★

Name & Surname		
Contact numbers:	(c)	(h)
Name & Surname		
Contact numbers:	(c)	(h)

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Background Information

Have you to a Psychologist before?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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If YES please complete info:

Date:	
Doctor:	
Reason for visit:	

Please give a brief description of your purpose in seeking therapy/coaching/assessment at this stage:

Is there anything that you feel the doctor should be aware of?

Have you ever attempted suicide? Yes No

Please note that suicide, or attempts at suicide are viewed in a very serious light, and while under the care of this practice, such actions are not permissible.

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Person Responsible for the Account

Name:

Surname:

Identity Number:

Gender:
 M F

Age:

Marital Status: Single Married Divorced

Contact numbers: (c) (h)

E-mail address:

Work Address:

Postal Address:

 Postal Code

Home Address:



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Terms and conditions

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each party. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in therapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your wellbeing. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

My Responsibilities to You as Your Therapist

Confidentiality:

- With the exception of certain specific exclusions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy. You may direct me to share information with whomever you choose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you.
- If you decide to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider.
- Please note: My administrative team and Medical Practice Billing Solutions (3rd party responsible for my practice's accounts) will have access to some of your personal information for administrative purposes only. My administrative team and Medical Practice Billing Solutions have both signed a confidentiality agreement binding them to only use this information for the purpose it was meant for.

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The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

- If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
- If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.
- If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the police crisis team. I am not obligated to do this, and will explore all other options with you before I take this step. If at that point you are unwilling to take steps to guarantee your safety, I will call the crisis team.
- I keep very brief records, noting only that you have been here, what interventions happened in session, and the topics we discussed. You have the right to request that I correct any errors in your file in terms of personal information. I am not, by law, allowed to give you the notes made in your file. You however, have the right to request that I make a copy of your file available to any other health care provider who is able to interpret the notes in the correct way, at your written request. I maintain your records in a secure location that cannot be accessed by anyone else.
- You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better.

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Appointments and accounts:

- Please note: If an appointment is not confirmed before 12:00 the day before the scheduled appointment, the appointment will be cancelled.
- If an appointment is not cancelled and the patient did not show up or make arrangements, the patient will receive a cash account for which they will be personally responsible.
- Accounts older than 90 days overdue will be handed over for collection.
- Please note that this is a PRIVATE PRACTICE, therefore the patient is responsible for the consultation fee of R1100 more or less 60 min. Payments can be made via card or cash directly after the the consultation takes place.
- Medical aid is accepted if you are admitted to a Psychiatric Hospital. When funds are depleted, you will personally be liable for any amount the medical aid did not cover.
- You are responsible for coming to your session on time and at the time we have scheduled. If you are late, we will end on time and not run over into the next person's session.
- If a patient misses three consecutive sessions, any time slots allocated to them thereafter will be reallocated to other patients.

★Please note: The person who is allocated as the main member or as the person responsible for the account will be personally liable for the accounts if the account was not paid by the patient or medical aid.★

Emergencies:

- For emergencies between 07:30 – 16:00 please call the office. After hours please call Vista Clinic: 012 664 0222 or Denmar Psychiatric Hospital: 012 998 6062/3/4/5.
- Messages will be retrieved at regular intervals. Intercare Practice Landlyn
- 012- 9954361 or whats up 0716024408
- Always leave all your contact details when leaving a message.
- Should the assessment be that you are a danger to yourself, hospitalization may be considered.
- The Psychologist bears no responsibility should you follow a course of action that may harm you.
- By signing this contract you give full consent for this practice to communicate appropriately with other professionals or with yourself via electronic media, i.e.: E-mail, sms, voicemail.

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For remote sessions [Skype, telephonic, instant messaging, e-mail]:

- Clients should complete and send back all the required paperwork, including this contract, prior to the session to prepare the therapist and the client for the session.
- All payments are to be made prior to the session at the rate agreed with by the practice.
- Clients are responsible for making the call for the session. If unable to, the cost will be added to the invoice as per service provider rates.
- This practice will ensure confidentiality as far as possible, however the client takes note that electronic media is NOT a confidential medium.
- This practice does not invite or respond to invitations to participate in profile based networks [Twitter, Facebook, MySpace,, WhatsApp] for confidentiality reasons.
- Where possible the Psychologist would like an established relationship with an individual before electronic sessions take place.
- This practice will attempt as far as possible to check mails at least every second day.
- When the therapist is on leave – alternate arrangements will be made.
- Where possible please ensure an undisturbed space where you will be able to reflect and concentrate while taking part in an electronic session.
- Please be aware that connectivity issues are rife – please have an alternative option available while in session should the connection break.
- This practice does not respond to ‘please call me’ sms’s.

REPORTS:

Please note that I do not write sicknotes or Psychological Reports (Including Divorce cases or school reports or request from your Insurance).

By signing this contract you give full consent for this practice to communicate appropriately with other professionals or with yourself via electronic media, i.e.: E-mail, sms, voicemail. I am fully aware of the contractual agreement between the Psychologist and myself. As such I agree to pay all costs on the Attorney and client scale in the event of it becoming necessary to institute legal proceedings against me, due to the failure to abide by the terms of this agreement. I also agree to undertake to pay all and any collection commissions and all value added tax, should it become necessary to institute action against me for said non-payment.

I, _____ ID number: _____

herby acknowledge that I read and understood the terms and conditions of this contract. I agree that I will comply with this contract.

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Signature:

Date:

20__

Thank you choosing TherapistBox. It is an honour to be invited on a journey with you.

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