Cherilee Botha

Counselling Psychologist

BA (Wits) BA Hons (Wits)
BPsyc Equivalent Psychometrics (Wits) (Cum Laude)
MA (Wits) (Cum Laude)
HPCSA Registration: PS 0128155
Practice Number: 0580910

Client Details and Consent - Group Psychotherapy

Client Details

Full Name: ____ Preferred Name: ___________________________

Date of Birth: ____________________________ Identity Number: ____

Email Address: ____ Contact Number: _________________________

Important Notice:

- Session length is 60-120 minutes. Session fees are up to R510 per session.
- The client is primarily responsible for payment of accounts for services rendered.
- Medical Aid Funds differ regarding benefits payable for psychological services rendered. Please contact your Medical Aid Fund promptly to confirm their rules and benefits in this regard. Should your Medical Aid Fund not cover the session fees you are responsible for full payment of sessions and consultations.
- By signing this document, you acknowledge that you have read the accompanying *client information document*, either through hard copy or electronically on the practice website, clarified any uncertainties, and that you consider yourself bound to the contents thereof.
- All efforts to maintain confidentiality and protect your personal information are taken according to HPCSA Guidelines and the POPI Act.

I____ patient in Section F at Netcare Mulbarton Hospital give Cherilee Botha Counselling Psychologist consent to access a copy of my admission printout (containing my personal information) from my hospital file as well as to keep a record of my attendance for group therapy. I also consent for Cherilee Botha to make clinical process notes as necessary in my hospital file as record of my treatment progress which will be available to my treating psychiatrist and other health care professionals involved in my treatment during admission. The purpose of obtaining this information is for Cherilee Botha to provide Counselling Psychology services during my treatment, to formulate invoices to bill my medical aid for services rendered, and to communicate pertinent information with my healthcare professional team while in hospital.

I, ____hereby give my informed consent to Cherilee Botha to continue with the required psychological assessments, evaluations, diagnosis and/or therapies as needed. I have read and understood the terms as per the *client information document*.

_____________________ ________________

Client Signature *Date*

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