Cherilee Botha Counselling Psychologist

BA (Wits) BA Hons (Wits) BPsyc Equivalent Pyschometrics (Wits) (Cum Laude) MA (Wits) (Cum Laude)
HPCSA Registration: PS 0128155 Practice Number: 0580910
Cell: 083 410 9883
www.cherileepsychologist.com
cherilee.psychologist@gmail.com

Client Details: Adults

Client Details:

First Names: _____ Gender: _____

Surname: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Identity Number: _____

Email Address: _____

Postal Address: _____

_____ Code: _____

Residential Address: _____

_____ Code: _____

Home Contact Number: _____ Cell Number: _____

Preferred Number to Contact Client On: _____

Highest Level of Education: _____

Medical Aid Scheme: _____ Medical Aid Number: _____

Main Member of Medical Aid: _____

Psychiatrist: _____ General Practitioner: _____

Person Responsible for the Account (Ignore if same as above)

First Names: _____

Surname: _____

Identity Number: _____ Relationship to Client: _____

Employer: _____ Cell Number: _____

Email Address: _____

Preferred Number to Contact Client On: _____

Emergency Contact

Full Names: _____

Contact Number: _____ Relationship to Client: _____

Referral Information:

Referred by: _____

Reason for referral: _____

_____

_____

Important Notice:

Session length is 50 minutes. Fees are charged at Medical Aid Rates or private rate of R900 per session.

Feedback interview session length is 30 minutes at a fee of R450.

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 on the day of the consultation.
Appointments should be cancelled 24 hours in advance. A cancellation fee of R600 will apply if appointments are not cancelled 24 hours in advance. This fee may not be covered by Medical Aid Funds.
You acknowledge that the practice is not liable for any loss, injury or illness, including COVID-19.
You acknowledge the limitations to confidentiality of using virtual 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.

Consent Agreement

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*. I give consent to access my personal information within the guidelines of the HPCSA and POPI Act.

Client Signature: _____ Date: _____

Person Responsible for Account Signature: _____ Date: _____

Psychologist Signature: _____ Date: _____