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: Children & Adolescents

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: _____

Caregiver's Information:

Caregiver Full Names: _____

Relationship to Client: _____ Identity Number: _____

Home Contact Number: _____ Work Contact Number: _____

Cell Number: _____ Email Address: _____

Preferred Number to Contact Client On: _____

Highest Level of Education: _____

Occupation: _____

Employer: _____

Residential Address: _____

Caregiver Full Names: ____

Relationship to Client: ______________________ Identity Number: ______________________

Home Contact Number: ____________________ Work Contact Number: __________________

Cell Number: ____________________ Email Address: ______________________________

Preferred Number to Contact Client On: ____

Highest Level of Education: ____

Occupation: ____

Employer: ____

Residential Address: ____

Caregiver Full Names: ____

Relationship to Client: ______________________ Identity Number: ______________________

Home Contact Number: ____________________ Work Contact Number: __________________

Cell Number: ____________________ Email Address: ______________________________

Preferred Number to Contact Client On: ____

Highest Level of Education: ____

Occupation: ____

Employer: ____

Residential Address: ____

Caregiver Full Names: ____

Relationship to Client: ______________________ Identity Number: ______________________

Home Contact Number: ____________________ Work Contact Number: __________________

Cell Number: ____________________ Email Address: ______________________________

Preferred Number to Contact Client On: ____

Highest Level of Education: ____

Occupation: ____

Employer: ____

Residential Address: ____

Person Responsible For the Account

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 45 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/caregiver 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/assent 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.

I, _____ caregiver of _____hereby give my informed consent/assent 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: _____

Caregiver Signature: _____ Date: _____

Caregiver Signature: _____ Date: _____

Caregiver Signature: _____ Date: _____

Caregiver Signature: _____ Date: _____

Person Responsible for Account Signature: _____ Date: _____

Psychologist Signature: _____ Date: _____