Dr Candice Leith
Counselling Psychologist

Supporting Every Mind,
Every Journey

CLIENT INFORMATION & PAYMENT DETAILS

By providing the information below you consent to this information being kept and processed for the purposes of providing treatment and for this information to be used to contact you when necessary. You also agree to notify me of any changes/updates to the information provided below.

Personal Information (If a patient is a child of under 14 years of age, please fill in his/her details here):

Full Name:	DOB	Age:
ID Number:		
Cell Number	Home No.:	
Residential Address: Code:		
Email address:		
Occupation:	Work No.:	

By providing the information below, you confirm that you have obtained consent from the person listed to provide their contact details as the person who will be contacted in the case of emergencies. You also agree to notify me of any changes to this emergency contact information.

Emergency Contact (Parent if child is under 14 years):
Relationship:
Cell No.:

By providing the information below, you confirm that you have obtained consent from the person listed to provide their contact details as the person who will be responsible for payment of your account. You also agree to notify me of any changes/updates to the information provided.

Person Responsible for Account (if different from above):

Full Name:	ID Number:
Cell Number:	Landline.:
Email address:	
Postal address: Code:	

Payment Options Cash at session ◯ Cash by electronic transfer ◯ Medical Aid ◯ Zapper ◯

Fees: 100% Medical Aid Rates or Cash at R1100 per 60-minute session

International Fees: Payments made through PayPal or other means the cash rate is R1300 per 60-minute session due to bank charges

Fee Increases: January each year

Medical Aid Details:

Medical Aid Scheme:	Medical Aid Number:
Option/Plan:	Dependent Number:
Full Name of Main Member:	DOB:

Note 1: Using your name as payment reference will reflect on practice bank statements and payment notification emails/SMS's.
Note 2: If medical aid funds become depleted it is the responsibility of the client to settle fees owing.
Please cancel appointments 24 hrs in advance so that your session time can be given to someone else. Unfortunately, failure to do this will result in the session being charged for.

Note 3: when claiming from a Medical Aid I must supply a diagnosis code on the invoice for them to make payment.

INFORMED CONSENT

Confidentiality

1. I hereby consent to being seen for psychological services by Candice Leith. I understand that general standards of confidentiality will always be maintained.
2. I understand that there are specific and limited exceptions to this confidentiality where the psychologist is ethically bound to prevent such danger / notify proper authorities
   (a) When there is risk of danger to myself or to another person.
   (b) When there is suspicion that a child / elder is being sexually / physically abused or is at risk of abuse.
   (c) When a valid court order is issued for records.
3. At certain times, I may request the assistance of another professional in providing quality care to you. In such cases, I will discuss relevant aspects of your situation with this professional. All identifying details and irrelevant material will remain protected and confidential.

Collection of information

4. I understand that information that will be gathered will be written up as confidential records and session notes. These records will also include any correspondence and communication between us that is required to provide a psychological service, as per the HPCSA regulations and the Protection of Personal Information Act No. 4 of 2013 (POPIA).
5. I understand that this information will only be used for the purposes for which it was collected, to provide psychological services. I understand that without this information, the provision of such services will not be possible. I understand my obligation to provide any updates or changes to this information.
6. I understand that appointments are hand-written in a diary and my first name is used to capture this appointment.
7. I understand that if I use my personal name as a reference for electronic payments, this will be reflected on the bank statements of Candice Leith. This means that they may be seen by my Tax Consultant, for the purposes of income tax calculations and submissions. The tax consultant has a privacy agreement with Candice Leith, however it is recommended that you use your initials only as a reference when making electronic payments.

Storage of information

8. I understand that my personal information will be stored in physical (informed consent form) and electronic (session notes and reports) formats. This information will be securely stored electronically on the personal computer of Candice Leith and backed up in cloud storage. All files are password protected to prevent breach of confidentiality.
9. Security safeguards on personal information storage will be reviewed on an ongoing basis.
10. Your records will be kept for a period of 6 years as per the HPCSA requirements, after which they will be safely disposed of.

Disclosure/Protection of information

11. I understand that Candice Leith may need to disclose my information to service providers who are involved in my care to enable the delivery of services to you, such as medical schemes or other health care professionals. This will always

be in service of your treatment and where such third parties comply with requirements as regulated by POPIA. This may include processing and sharing information for the purposes of collecting unpaid debts.

12. I understand that where specific requests are received to disclose information contained in your records (eg. medical aid audits), a separate consent to disclosure form detailing the particulars of this request will be provided to you.
13. The above-mentioned third parties include email and text messages to service providers, including WhatsApp and Gmail, and cloud storage providers. Password protection is in place to secure your information stored on these virtual platforms and I will take reasonable steps to ensure that the privacy protections that such third parties have in place comply with the regulations of POPIA.

Client rights with regard to information

14. As per the Promotion of Access to Information Act (PAIA) and the processes outlined in the PAIA manual for this practice (this manual is available directly from Candice Leith on request), you have a right to request a copy of the personal information that I hold about you, the copying and provision of which may be subject to payment of a legally allowable fee. The PAIA manual and Form C for requesting information can be requested directly from Candice Leith, or Form C can be accessed from the POPI website.
15. I understand that I have the right to object to the processing of my personal information. This process of objection can be done formally by completing Form 1 from POPI. This can be requested directly from Candice Leith or is available from the POPI website.
16. I understand that I have the right to request Candice Leith to update, correct or delete any personal information by completing Form 2 from POPI. This can be requested directly from Candice Leith or is available from the POPI website.
17. The responsibility for compliance with POPI and PAIA lies with the registered information officer for this practice, Candice Leith.

Signature: ……Name: ……. Date: …….

Dr Candice Leith (Counselling Psychologist) ……

Date: ……..……

TELEMENTAL HEALTH INFORMED CONSENT

1. I hereby consent to participate in telemental health with Candice Leith as part of my psychotherapy.

2. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telemental health:

3. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

4. I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

5. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

6. I understand that general standards of confidentiality will be maintained at all times.

7. I understand that there are specific and limited exceptions to this confidentiality where the psychologist is ethically bound to prevent such danger / notify proper authorities
   i. When there is risk of danger to myself or to another person.
   ii. When there is suspicion that a child / elder is being sexually / physically abused or is at risk of abuse.
   iii. When a valid court order is issued for records.

8. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

9. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at_____ to discuss since we may have to re-schedule.

Signature: ……Name: …… Date: ……

Dr Candice Leith (Counselling Psychologist) ……

Date: ……

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