**1. Patient Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Surname |  |
| Date of Birth |  | | |

**2. Person Responsible for Account**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Title, Name, Surname |  | | I.D. No |  | | |
| Residential Address |  | | | | | |
|  |  | | | | | |
| Postal Address |  | | | | | |
|  |  | | | | | |
| Employee Name and Work Address |  | | | | | |
|  |  | | | | | |
| Contact No’s | Home |  | | | | |
|  | Cell |  | | | | |
|  | Work |  | | | | |
|  | Fax |  | | | | |
|  | E-mail |  | | | | |
| **Medical Aid** Name |  | | Medical Aid No | | |  |
| Principal Member Name |  | | I.D. No | |  | |

**3. Family Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Close family member |  | Contact No |  |
| E-mail Address |  | | |
| Brief Description of trauma/difficulties | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/s / Guardian/s Signature: Date

**CONTRACT**

**Please read, then, tick each point as confirmation of acceptance thereof**

A rate of **R450 per 1 hr session** will be charged for counselling.

Please make bookings online and note that this practice is run on a **cash-up-front** basis. Bank details are provided below.

Appointments not cancelled the day before, will be charged at the full standard rate. After the 2nd missed session the weekly slot will be re-allocated.

Reports **will not** be written.

No court work, court reports, consultations with legal representatives will be entered into.

Counselling will not commence prior to this contract being completed and returned via email: kateswaterston@gmail.com.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/s / Guardian/s Signature:Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Counselor Date