**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 |       |

**4. 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 **R650 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.

[ ]  It is the Clients responsibility to claim from their Health Care Provider.

[ ]  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: clairedejagertherapy@gmail.com.

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

Parent/s / Guardian/s Signature:Date

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Worker/Counselor Date