**1. Patient Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s Name |  | Child’s 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**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mother’s Name |  | Contact No | |  |
| e-mail Address |  | | | |
| Father’s Name |  | Contact No | |  |
| e-mail Address |  | | | |
| Child’s School |  | | | |
| Teacher |  | Contact No |  | |
| Brief Description of Child’s trauma/difficulties | | | | |
|  | | | | |

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

Parent/s / Guardian/s Signature: Date

**CONTRACT**

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

The average length of therapy is six weeks (depending on your child’s area of need).

A rate of **R400 per 30-40min session** will be charged for **children’s play therapy**. (This charge includes regular teacher consults with techniques to assist the child in the classroom and parental advice given either telephonically or via email, if necessary, during the therapeutic process).

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

A compulsory interview with the parent/s is required to gather background information before therapy commences. (Charged at a **rate of R400.)**

Practice is run on a **cash-up-front** basis. Internet payments must be made to secure a booking online and prior to the commencement of the child’s session. Bank details are provided below.

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

**In the event that the child’s parents are divorced or separated this form MUST be signed by both parents.**

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 as feedback is verbal.

No court work, court reports, consultations with legal representatives will be entered into as the play therapy is purely for the healing and support of the child.

Verbal feedback to the parents will be given at completion of therapy once the account is fully settled. (Charged at a **rate of R400.)**

Requested attendance at teacher/parent meetings will be charged at a **rate of R400 per meeting.**

Therapy will not commence prior to this contract being completed and returned.

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

Parent/s / Guardian/s Signature:Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Worker/Play Therapist Date