**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