**Intake Form / Client Details**

**Name:**

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Suburb:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mobile:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your current gender identity? (Check ALL that apply)**

☐ Male ☐ Female ☐ Transgender Male/Transman/FTM ☐ Transgender: Female/Transwoman/MTF ☐ Gender Queer ☐ Additional category (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Decline to answer

**What pronouns do you prefer that we use when talking about you? (check all that apply)**

 ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other: Please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been provided with information about the service including the limitations to privacy and confidentiality and I have agreed that in circumstances where the psychologist is concerned about my welfare and is unable to contact me permission is provided for the psychologist to contact the following person:

**Emergency Contact- Name / Number and relationship to you:**

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

Medicare Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiry Date: \_\_\_\_\_\_\_\_\_\_

IRN Number: \_\_\_\_\_\_\_\_\_\_ (number next to your name on the card)

Referred by / GP details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your payment type? *Referrals and all payment details needed at first appointment.*□ Mental healthcare plan rebate □ Private □ Workcover/TAC □NDIS □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Services and Consent Policy**
To ensure the welfare, satisfaction and protection of privacy for all our clients, psychologists operate in accordance with the following service and consent policy. Please read and sign the following policy. If you have any questions about this service agreement, please feel free to discuss these with your psychologist.

**Fees**

All fees are to be paid at the time of consultation (Cheque / EFTPOS / Credit Card Available) unless you are provided a special exemption by your psychologist. The out-of-pocket expense on Medicare rebated sessions acquired through a Mental Health Care Plan from your GP is $93.35, with full fee sessions costing $230.

If funding is rejected for psychology services from any alternative referral sources clients will be responsible for full payments of any unpaid accounts.

**Information and Confidentiality**

Your psychologist will need to collect and record personal information from you that is relevant to your current situation. This information is a necessary part of the psychological assessment and treatment.

All personal information gathered by your psychologist is treated as confidential and secure. Apart from communicating with your referring GP or Medical Specialist, we will not disclose any information about you to anybody or any organisation without your permission unless:

1. Mandated by a court of law.
2. We identify a threat to the safety of yourself, or someone else. In such an event, reasonable effort will be made to discuss this with you prior to any disclosure.
3. Or you are a Primary Mental Healthcare (PHN) client as the funding is dependent on measurement outcome reports being reported to the PHN and GP.

For service quality, and practice supervision purposes, clinical sessions may be recorded via audio and/or video means. Any recording is treated as strictly confidential.

Where appropriate the service may be provided by telephone or videoconferencing. You are responsible for the costs associated with setting up the technology needed so you can access telehealth services. Suzanna Copp Psychology will be responsible for the cost of the call to you and the cost associated with the platform used to conduct telehealth services.

To access telehealth consultations you will need access to a quiet, private space; and the appropriate device, i.e. smartphone, laptop, iPad, computer, with a camera, microphone and speakers; and a reliable broadband internet connection.

The privacy of any form of communication via the internet is potentially vulnerable and limited by the security of the technology used. To support the security of your personal information this practice uses Power Diary which is compliant with the Australian standards for online security and encryption.

**Limitations of telehealth**

A telehealth consultation may be subject to limitations such as an unstable network connection which may affect the quality of the psychology session. In addition, there may be some services for which telehealth is not appropriate or effective. Your psychologist will consider and discuss with you the appropriateness of ongoing telehealth sessions.

**Research**

Assessment and treatment information may be utilised for clinical research and service evaluation purposes. All identifying information and names will be omitted from any such usage and will remain completely confidential. You have the right to withdraw participation in research at any time.

**Cancellation Policy**

Last minute cancellations or 'no-shows' mean that other clients miss out. A cancellation policy has been established to limit this from occurring. Please inform us the day prior to your scheduled appointment to notify us of any changes or cancellations. If prior notification is not given, you will be charged a late cancellation fee of $100.

**Declaration**

I have read, understood, and agree with the Services and Consent Policy. I agree to the above conditions for Face to Face or Telehealth Psychological services to be provided by Suzanna Copp Psychology.

*Signature/Date*

**OR** Where a signature is not possible Psychologist’s confirmation of Verbal consent: I Have discussed the information in the consent form with the client and received verbal consent to proceed with Telehealth services.

*Signature/Date*How did you hear about us?
□ Your GP □ Another health service □ Internet □ Newspaper □ Word of mouth

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_