Dr. Marisa van Niekerk

Educational Psychologist

HED Junior-Primary; HED Pre Primary; Hons. B.Ed (Early Childhood Development); Hons. B.Ed (Guidance and Counselling suppl); M.Ed (Guidance and Counselling); D.Ed (Psychology of Education)

HPCSA Reg. no: PS 0122432 **Practice no: 0523240**

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Consulting Rooms:
170 Old Kent Drive
Midstream Estate, 1692

Consulting Hours:
Mon-Fri: 09:00-18:00

CLIENT INFORMATION

CLIENT			
Surname:		Title:	
Name:			
ID number / Date of birth:			
Postal address:			
		Code:	
Residential address:			
		Code:	
Tel. No. (Cell):	(W):	(H):	
Home language:	Grade in school:		Age:
Marital status:	Name of school:		
PERSON RESPONSIBLE FOR ACCOUNT			
Surname:		Title:	
Name:			
ID number:			
Occupation:		Employer:	
Work address:			
		Code:	
Residential address:			

		Code:
E-mail address:		
Tel. No. (Cell):	(W):	(H):
Name of 2nd parent:		Title:
Occupation:		
E-mail address:		ID number:
Tel. No. (Cell):	(W):	(H):
Names and ages of other children in family:		
Marital status of parents:		
Medical aid:	**Medical aid number:**	
Main member:	Dependent No:	
Name, contact number and relationship of family member / friend not living at the same address:		
Name:	Tel:	Relationship:
GENERAL PRACTICIONER		
Initials and surname:	Tel. No:	
NAME AND ADDRESS OF CONTACT PERSON IN EMERGENCY		
Name:		
Address:		
		Code:
Tel. No:		

PROFESSIONAL AGREEMENT

Reports: In terms of the ethical code, with reference to forensic activities and/or reports, this psychologist does not provide forensic reports.

1. CONSENT TO ASSESSMENT AND THERAPY

I the undersigned, hereby give my consent to the psychologist of this practice to:

1.1. To interview myself / the client and perform an assessment, and proceed with the relevant therapy and/or medical hypnoanalysis.

1.2. To gather / give information from / to relevant parties as agreed, provided that it is done in the interest of myself / the client / a family member / or other relevant parties.
1.3. That the information gathered throughout our interaction could be used anonymously and confidentially for research, training or supervision purposes.

2. CONFIDENTIALITY:

The Ethical Code of the HPCSA, as well as the Protection of Personal Information [PoPI] Act 4 of 2013, requires the psychologist of this practice to treat all information as confidential, except in the following circumstances:

2.1 where there is a risk that the client and/or another person's life is in danger;

2.2 where the client gave his/her consent that the information may be shared;

2.3 where a court of law / or a legal statute requires the psychologist to disclose the information,

2.4 medical aids require a therapeutic code for payment of your invoice.

The client's rights with regards to his/her personal information, in terms of the PoPI Act, can be found in the following link:
http://www.justice.gov.za/legislation/acts/2013-004.pdf

3. TERMINATION OF THERAPY:

The client or the psychologist may terminate the therapy at any stage. Should the psychologist terminate the therapy, it will be done in a professional manner, in consultation with the client.

4. ADDITIONAL INFORMATION:

The client is encouraged to ask questions during the sessions if anything is not clear to him / her.

5. ENTERING OF SITE AT YOUR OWN RISK

The client enters the premises and consulting room at own risk. The psychologist does not accept and responsibility for any loss and / or injury of any kind that may be sustained on the premises.

6. PERMISSION TO ASSESSMENT OF CHILDREN OF DIVORCED CHILDREN

Both parents (including married, divorced or separated) must give permission to the assessment. It is the responsibility of the parent(s) to inform the psychologist if they are divorced or separated.

7. FEES

I, the undersigned, take note of and agree to the following:

7.1 This practice is run on a cash basis. Fees are charged in line with those prescribed by the "Board of Healthcare Funders" (BHF). The cost per 45-minute (or shorter) therapy session is R 1 050.00. Fees for sessions longer than 45 minutes are adjusted on pro-rata basis.

7.2 Fees for assessments are not based on time. The fee for a specific assessment will be sent to me by e-mail before the assessment.

7.3 An invoice will be sent to me after the session.

7.4 I agree to settle the full amount of the therapy / assessment on the day after the session took place. _____ (Initial here please)

7.5 The fact that the invoice states a Practice number and BHF codes (as required by medical aids) does not guarantee that your medical aid will pay the account.

7.6 This practice is not contracted with any medical aid, and does not handle the administration of any claims directly with any medical aid. Clients pay invoices directly to the practice, and can then, after payment, claim back from their medical aid. Please do not send unpaid invoices to the medical aid requesting them to pay the practice directly._____ (Initial here please)

7.7 Accounts are only settled by EFT (electronic funds transfer).

7.8 Bank account details: (please use the customer code on the invoice as reference)

AMS van Niekerk
Bank: Investec Private Bank
Branch: Grayston Drive
Branch code: 580105
Account number: 10011159586

7.9 A full consultation fee will be payable if I do not cancel my appointment at least 24 hours before the time, or if I do not show up for a scheduled appointment.

7.10 I will not use the psychological reports supplied by the psychologist for legal proceedings.

7.11 Should my account not be paid in full, it will be referred to an attorney, and all legal costs will be for my account.

Signature: _____ Name: _____

Person responsible for account: _____

Signed at _____ on this _____ day of _____.

SIGN UP FOR MY FREE NEWSLETTER

I would like to sign up for your free 6-weekly newsletter.

YES	NO

Herewith I agree that the free newsletter may be sent to the following e-mail address: _____

Signature: _____