

# Heather Thom

B.Prim Ed (Art) B.A. Hons (Psychology) B.Psych (Equivalent)

REGISTERED COUNSELLOR

HPCSA Number: PRC 0039918

Practice Number: 1120816

+27 66 200 1222

info@registered-counsellor.co.za

19 The Crescent, Pinelands, Cape Town, 7405

## 1. CLIENT'S DETAILS

TITLE	Name:	Surname:	Age:
ID number:	Date of birth:		
Address:			Code:
Telephone: Home	Work:	Cell:	
Email:			
Level of Education / Grade:		School:	
Occupation:		Employer:	
Business Address:			

## 2. PERSON RESPONSIBLE FOR PAYMENT (IF NOT THE CLIENT) AND IN THE CASE OF A MINOR

	Mother's / Partners Details	Father's / Partner's Details
Name:		
Surname:		
Date of Birth:		
ID Number:		
Address:		
Occupation:		
Employer:		
Business Address:		
Tel Home:		
Work:		
Cell:		
Email:		

## 3. MEDICAL AID DETAILS

Medical Scheme:	Plan/ Option:
Membership no:	Main Member:
Main Member ID:	Main member Ph:
Medical Practitioner:	Tel:
Referred by:	

## 4. HISTORY AND MEDICATION

Previous counselling: Y/N	When & reason:
Medication (current): Y/N	Name & purpose & duration:

## 5. REASON FOR COUNSELLING


Client's Initials : \_\_\_\_\_

## Client's Informed Consent

- **I provide psychological counselling services** and appropriate referral to support and enhance personal functioning in a variety of life contexts. I offer screening, psychometric assessment, psycho-education and counselling interventions within my scope of practice as a Registered Counsellor. I do not diagnose or treat psychopathology.
- **The content of our sessions is confidential.** Client consent is required before information can be shared with a third party. However, I may be required to share client information without consent if compelled by a court order or when required by law to act to avoid anticipated harm to my client, a child, or a vulnerable adult.
- **I record sessions in written, audio or video form.** As per Section 13 of the National Health Act (Act No 61 of 2003) I am required to keep specific health care records. In accordance with this Act, I may confidentially share non-identifying data with trusted qualified and registered colleagues for supervision purposes to increase my counselling skills and to ensure best practice.
- **Protection of Personal Information Act No 4 of 2013.** I may disclose client personal information to service providers who are involved in the delivery of services to the client (i.e. for billing and/or medical aid purposes). Invoices may contain ICD10 procedure codes for clients who provide their medical aid details and such codes may be used by medical aids to process claims.
- **I offer counselling that is face-to-face and on-line if need be.** Whilst there are security features to online platforms and every best care is taken to protect the content of online counselling sessions, clients should be aware that there are risks inherent in electronic transmission of conversations for which I am not responsible.
- **I offer sessions from 8am to 5pm.** Clients are invited to schedule their own sessions via my website or to contact me on WhatsApp.
- **Rates for 2024:** Payments may be made by cash or EFT. A 5% discount is offered if the account is settled on or before the day of consultation. These rates are not medical aid rates and the client is liable for the full rate charged. Psychometric assessments are generally not covered by medical aid. **Clients are responsible for submitting their own claims to medical aid.**
  - R700-00 per 50-minute consultation. Collateral information obtained via email correspondence, school visits or telephonic consultations will be charged for at a rate of R190-00 per 15 minutes.
  - Psychometric Assessment:
    - School Readiness Assessment: R3500-00 (report included)
    - Subject Choice Assessment: R3000-00 (verbal feedback and written summary included)
  - Groups: R350-00 per 2-hour session
- **In the event of a divorce where both parents are liable for costs, each parent is responsible for half the fee payable.** Each parent will be billed separately.
- APPOINTMENTS NOT CANCELLED WITHIN 24HRS WILL BE CHARGED AT THE FULL CONSULTATION RATE.
- This practice will not accept responsibility for accidents / mishaps encountered by clients during visits.

Signed at \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_ year \_\_\_\_\_

\_\_\_\_\_  
Client's signature

\_\_\_\_\_  
Parent(s) or guardian(s) (if the client is a minor)

**Please indicate by signing:**

Consent to obtain collateral information: \_\_\_\_\_

Separate billing for parents: \_\_\_\_\_

Permission for non-identifying data to be used for statistical, research and/or training purposes \_\_\_\_\_