Christelle Duckitt
Educational Psychologist
M.ED.PSYCH (STELL)

CONSENT FORM 2024

Client / Child's details:

Surname:	Date of Birth:
First name:	ID number:
Contact number:	Language:
Residential address:	
School:	Language at school:
Next of kin:	Contact no:

Person responsible for the account:

Surname:	Name:
Relationship to client:	ID number:
Contact number:	Email address:
Residential address:	

Medical aid details:

**Please note: You are responsible to check if funds are available if you want this practice to claim directly from the medical aid.*

Medical aid name & Plan:
Medical aid number:
Dependent code:

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Protection of Personal Information Act (POPIA):

I _____ (full name) hereby consent to the processing of my / my minor child's (under 18 years old) personal information contemplated in the Protection of Personal Information Act No.4 of 2013, by Ms. Christelle Duckitt (Educational Psychologist), the practice staff and third parties with whom Christelle has a contractual relationship for the following purposes:

• Treating and managing me or my minor child in terms of a psychologist-and-patient **relationship**;
• The administration of the contractual relationship between myself / my child and Christelle Duckitt;
• Communicating with other persons as it relates to my / my minor child's treatment and **management;**
• Communicating with third parties who have undertaken to indemnify me for the costs of my / my child's treatment and management or part thereof including medical schemes and their administrators where relevant; and
• Collecting monies outstanding from me / my minor child's sessions.

As you are entering into a contract with Christelle Duckitt, the processing of your personal data is necessary. I take the storing and accessing of your personal information very seriously and confidentiality is of utmost importance. Your personal information will be **stored securely at all times** and only accessed by me.

Further information about my practice and personal data:

- I am a registered senior Educational Psychologist with the Health Professions Council of South Africa (HPCSA).
- I have a BEdPsych (Educational Psychology) degree, as well as an MEdPsych (Educational Psychology) degree.
- I am trained in play therapy interventions, as well as Jungian Sandplay therapy and other therapeutic modalities. I am also trained to provide psycho-educational assessments and recommend interventions to the families and schools. My experience includes play therapy, individual psychotherapy, and parent guidance.
- The registration (PS0112003) allows me to practice in South Africa. I hold no other professional registration to work in another country (online or in person).
- According to the HPCSA regulations, I keep patient files for a period not exceeding 6 years, or, in the case of minor children, until they reach the age of 21 years.
- All client notes are stored in a secure, lockable, fireproof filing cabinet.

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Feesand payments 2024:

- **I run a cash and/or medical aid practice and a discounted cash payment is due on the day of your session** by EFT or via FNB Speedpoint card facility. You will receive a discounted cash rate of R900 per session **if paid before or on the day of the session**. Thereafter, the medical aid tariff rate of +-R1200 per session will apply.
- **Please note: Polmed does not cover Educational psychologists at all and GEMS only covers around R2700 per year.**
- **Tick appropriate method of payment:**
  - I prefer to pay the discounted rate of R900 cash on/before the day of the session ☐
    or
  - Please submit to my medical aid for the fee of +-R1200, I have checked that there are funds available. ☐
  - P**sycho-educational assessments:** Please see the detailed document regarding these assessments.

My practice banking details are as follows:
Account name: Christelle Duckitt Educational Psychologist
Bank: FNB Business Current Account
Account number: 630 228 60977
Branch: 250 655
Reference: Initial and surname

Prescribed Minimum benefits (PMB):

- **I cannot guarantee that a medical aid will approve Prescribed Minimum Benefits.** It is up to the client to decide whether therapy should commence while awaiting the outcome of the PMB application.
- In the case where the PMB has been approved, invoices are emailed directly to medical aids in PDF format and contain diagnostic and treatment information.
- . Please note that medical aids require an ICD 10 Code (diagnosis) on your invoice for payment of claims.
- I am only able to claim directly from your medical aid if you are approved for Prescribed Minimum Benefits (PMB). It is the client's responsibility to monitor medical aid funds available.
- Important: PMB benefits include up to 15 appointments per year (Psychology and Psychiatry included) or 21 days in a psychiatric hospital. It is the patient's / legal guardian of the minor's responsibility to keep track of the number of sessions used during the year. Once a PMB is applied for, this diagnosis remains on your medical record.
- Please note that fees are subject to an annual increase.
- If your account is not settled, the person responsible for the account will be liable as well as all legal and debt collection costs involved.

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Appointments:

- I use an electronic Calendar for booking of appointments via my website (www.christelleduckitt.com) or you can phone 087 138 8570.
- I email appointment reminders the day before your session. Please ensure that I have your private email address for all correspondence.
- A minimum of 24 hours' notice is required for all cancellations. Should the notice period be less than 24 hours, or should you not arrive, you will be charged in full for the session.
- Medical aids do not cover missed appointments – the fee will be for your personal account.
- Appointments are 50 – 60 minutes long. If you are late for an appointment, this will result in a shorter session time. Sessions cannot run overtime if you are late as this will impact the client scheduled after you.
- For online sessions, it is important to have access to a stable internet connection and have a private space for the session.
- I use Zoom or WhatsApp for online video sessions. The client can select which platform they prefer. No recordings of sessions are made without the prior written consent of both parties (client and therapist).

Limits to confidentiality:

Please note that the purpose of the therapy sessions is always to promote wellbeing and emotional development.

The therapeutic relationship is based on trust, therefore information shared with the psychologist will be regarded as strictly confidential, except for specific situations where ethical responsibilities demand disclosure.

Situations that the psychologist legally needs to disclose are:

1. A client threatening to harm him/herself
2. A client threatening to harm someone else
3. A client disclosing neglect or abuse
4. If the psychologist is subpoenaed by a court of law

Initial/Sign

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Final declaration

This consent is valid until termination of the therapeutic relationship. You have the right to revoke consent at any time. Verbal or written notification will be accepted. Please read this agreement carefully, and sign if you fully AGREE & UNDERSTAND these terms & conditions.

In order to authorise mental health treatment for your child (under the age of 18 years), you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorise treatment for your child.

NB: If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent and that BOTH PARENTS need to sign consent below. *I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment. One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honour that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a closing session with your child to appropriately end the treatment relationship.*

I, the undersigned, accept all the conditions mentioned above:

Full Name (Parent / Legal guardian 1)	Full Name (Parent / Legal guardian 2)
Date	Date
Signature	Signature