ROSEMONT PSYCHOLOGY

Deborah A. Stewart
Board Certified Psychology Supervisor
Registered Psychologist – MAPS
AHPRA: Reg #00013282029
Medicare Provider #: 4077582K
ABN: 32420571835

New Client Intake Form

(Information supplied in this form, is kept strictly confidential)

Personal Details

Title: Mr / Mrs / Ms / Miss / Master

Name: _____

D.O.B: _____

Address: _____

_____

Mobile: _____ Home / Other: _____

Email: _____

Occupation: _____

Relationship Status: Married / Single / De Facto / Separated / Divorced

Next of Kin - In case of emergency during session

Name: _____

Relationship: _____

Best Contact: _____

Medicare / Medical Details

Medicare Number: _____

Exp Date: _____

Doctor, GP: _____

GP Contact Details: _____

Specialist in care (Psychiatrist): _____

Medication: _____

_____

Mental Health Care / NDIS Plan Details

Mental Health Care Plan: Y / N NDIS Plan #: _____

Date of Issue: _____

Referring GP: _____

Referring Issues: _____

_____

_____

NDIS Plan Manager Details: _____

_____

Legal - Rosemont Psychology reserves the right to decline accepting clients involved in ongoing legal matters.

Current AVO on yourself or significant other: Y / N

Outstanding warrant or charges: Y / N

Current Illegal Drug Use: Y / N

Previous legal charges: Y / N

Involved in any custody or legal situations: Y / N

Court mandated therapy: Y / N

If YES, please specify : _____

_____

Service Agreement & Consent

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

Psychological Service

As part of providing psychology services, your psychologist will need to collect and record personal information from you that is relevant to your current situation. This information will be a necessary part of the psychological assessment and treatment that is conducted.

Fees - NDIS Fees will apply if applicable / Medicare Rebates will be available with a MHCP

All fees are to be paid at the time, or day of, consultation. (credit card service available in office).

Standard rates for Week Day Sessions – 1hr	
Initial Consultation	$150 – 50min
9am - 5pm - Session	$230 Adult
9am - 5pm - Session	$200 (13yrs-17yrs)
9am - 5pm - Session	$180 (3yrs - 12yrs)
5pm - 8pm - Session	$250 (All Ages)
Group Session w/ 2+ people	$250 p/h
School Visits - 40min & travel	$180 + $30

Alternative Services	
Assessment Consultation	$150 – 50min
Diagnostic Assessment Testing	$250 (p/h)
Assessment Report	$1000 (All Ages)
Additional Calls, Texts	$10 flat fee
Cancellation prior 24hrs	(50% session fee)
Family, Group Session w/ 3+ people	$300 p/h
Additional Reports / Letters	$50 p/pg

Confidentiality

Privacy and confidentiality for clients is a priority. We insist that this confidentiality be extended to all our clients. If you know another family who uses our service, please protect their privacy. Protection of your privacy is also ensured in this way.

All personal information gathered by your psychologist is treated as confidential and secure. Apart from communicating with your referring GP or healthcare specialist, we will not disclose any information about you or your family to any other agency or person without your permission **unless**:

a. Mandated by legal means, ie: through legal subpoena
b. We feel there is a threat to the safety or integrity of yourself, someone in your family, your psychologist, or to someone else. In such an unlikely event, every effort will be made to discuss this with you prior to any disclosure;
c. Your prior approval has been obtained to communicate with another professional/agency (e.g. GP or lawyer), organisation (e.g. your child's school) or person (e.g. a parent or employer).

***** Please note you are NOT considered a client at Rosemont Psychology until a service / intake agreement has been signed by the individual seeking services.

For service quality, supervision purposes, and to ensure the safety and security of both clients and psychologists, therapy sessions may be recorded via audio and/or video means. Any recording is treated as strictly confidential. Written permission will always be sought prior to the use of such recordings for any other reason, such as referral references.

Cancellation Policy - fees

Rosemont Psychology typically fills all available appointments. Last minute cancellations or 'no-shows' mean that others miss out. As such, a cancellation policy has been established. If for some reason you need to cancel or postpone your appointment, please provide at least 24 hours notice. Should an appointment be cancelled within 24 hours of the scheduled time, a cancellation fee of 50% of the session fee will apply. If the cancellation is due to a genuine emergency or family/child illness, the cancellation fee will be waived. Please provide paperwork to confirm.

Disclosure to Specific Third Party - fees

Under a Medicare Mental Health Care Plan, it is sometimes a requirement for our service to communicate with your referring GP or Specialist (e.g. provide correspondence with regard to referrals and update reports). This form of communication (including emails, telephone calls, and/or letters) is provided with an additional charge - see above for list of fee prices.

Client Declaration

I have read, understood, and agree with the Rosemont Psychology terms of service.

I hereby commit to **pay all fees** and compensation where required. I irrevocably authorise Rosemont Psychology (Deborah Stewart) to pursue legal action for the collection of monies owing, which may be any outstanding or owing fees or charges payable by me under this agreement.

I declare that all information provided by myself (or parent if underage) is true and correct, to the best of my ability.

I declare that I have not withheld any information, which may prove detrimental to the safety of myself, or others, including the practicing psychologist.

I declare that I have not withheld any information, which may hinder the progress of therapeutic treatment between myself, and my practicing psychologist.

I agree to all terms and conditions held within this document.

Name of client: _____

Signature of client: _____

Date: _____