Justin Scott Clinical Psychologist
PRA NO: 0556815 / PS: 0121703
Email: justinscottpsych@gmail.com
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Fourways Family Health Centre
2 Granite Road, Cnr Uranium Street
and Granite Road, Fourways, 2068

Informed Consent for Psychotherapy

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by placing your signature at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behaviour or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality.

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.

2. If a client threatens grave bodily harm or death to another person.

3. If a court of law issues a legitimate request in writing for information stated on the written document.

4. Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

5. If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

6. In some cases and as a last resort the practice does make use of a Debt Collecting Agency to retrieve monies owed. Identifying details such as Name and Surname; Physical and Postal Address; Identification Number as well as email address and contact numbers are used in an effort to retrieve what is owed to the practice. (Please refer to the section on Payments of Sessions for more info).

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Appointments and Cancellation Policy

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 50 minutes. **If you miss a session without cancelling, or cancel with less than *48 hours* , you are required to pay for that session, irrespective of the reason for the inability to attend. It is important to note that missed or cancelled sessions cannot be claimed back through medical aid.**

You are welcome to discuss the cancellation policy with me. The reason for having a cancelation policy is that I am only able to see a certain number of patients in a day, when a session is cancelled (without sufficient notice) or if you don't arrive for a session I am unable to full the time slot with a patient who is either on the waiting list or is in need of additional sessions. This then leads to an irrecoverable loss to the practise/myself.

Payment of sessions.

Payment is requested to be made on the day before our session. Payment can be made via:

EFT (please send POP)
Physical Cash
PayShap (search for this on your banking app): My PayShap ID: 0833965194

- If there is a query or dispute regarding an invoice, I am more than willing to discuss this with you.
- Any monies owed to the practice that has not been settled in full for longer than 30 days will be handed over for Debt Collection unless a prior arrangement has been made. Please take note of the following:
- In the case of medical aid payments/claims, you are financially responsible for payment should the medical aid not settle the account in full or not settle at all. I unfortunately do not have any control over of or have any knowledge of what funds are available in your savings account or regarding a particular benefit associated to your medical aid.
- If an account is handed over for collection then all identifying information such Full name, ID number, Address, Email and ICD-10 (International Classification of Diseases, Tenth Revision) code is provided in an effort to obtain what is owed. Any communication specifically regarding the attempted settlement of monies owed (this includes statements and invoices as well as any other correspondence) will be handed over to the Debt Collection Company. All other information regarding treatment or content of what has been discussed in session remains confidential).
- Arrear payments will bear interest at the rate of 2% per month in accordance with the National Credit Act and a service fee of R69.00 incl of vat in accordance to the National Credit Act. Arrear payments will be allocated to interest, cost then capital. You agree that in the event of any legal action instituted.
- You hereby and acknowledge that tracing on this agreement is allowed and choose the aforesaid address as my domicillium citandi et executandi for all purposes arising from this agreement.
- You hereby nominate the email address below for statements to be emailed and any legal notices.
- No variation of this agreement shall be valid unless reduced to writing and signed by both parties.

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Record-keeping

- In line with the standards set out by the **Health Professions Council of South Africa (HPCSA)** I do keep brief records, noting that you have been here, what interventions that may have been utilised during your session, as well as the topics that we discussed.

- I do make use of a billing and appointment software programme named **smeMetrics,** this means that information such as your full name, Identity number, address, Medical Aid details, ICD-10 code etc are stored on this software programme.

- Records and personal information are kept for a period of 6 years after the last session. Thereafter they are destroyed as per the **HPCSA** guidelines.

- In terms of the **Protection of Personal Information Act 4 of 2013 (POPI)** it is important to note that all reasonable precautions are taken to protect your confidentiality and personal information. Your information is always kept in a locked cupboard, information on my computer as well as on my phone is password protected with all the necessary antivirus programmes installed, however despite these precautions there remains a chance that a breech may occur (for example being hacked). If in the highly unlikely event of a breech occurring, please be aware that by signing this form you acknowledge that you cannot hold the practise/myself liable. The steps that myself/practise would take would be to inform the Regulator as well as all other relevant authorities of the breech.

Contact & Emergencies

You may contact me via phone, text or email (please note that email and text are not completely confidential.) If you are experiencing an emergency when I am out of town, or outside of my regular office hours (after 7 pm weekdays or over the weekend), please call Lifeline on (011) 715-2000, or go to the nearest hospital emergency room for assistance.

If there are any queries with regards to the above information, please don't hesitate to discuss this with me.

I, _____, have read, understood, and agreed to the Informed Consent for Psychotherapy practices contained herein.

Signature: _____ Date: _____

Email address: _____