MSc Clinical Psychology (NWU)
HPCSA # : PS011664
Practice # : 0484083

010 500 3231
079 238 6817
clinpsych@tarynsteyn.com
www.tarynsteyn.com

CLIENT AGREEMENT

A therapeutic relationship can only be successful when clearly defined rights and responsibilities are held by both client and therapist. In maintaining this, an environment is created that ensures the safety to take risks and provide support to empower and create change. *By signing this form you acknowledge that you have understood and agreed to the following:*

Appointments
Scheduled appointments will be agreed upon and will be a 51-60 minute session. In an event of a cancellation or rescheduling, 24 hours' notice is required. If you have missed a session without canceling you will be held liable for that payment. An amount of R250 will be charged for a missed appointment or late cancellation, this will not be claimed by your medical aid, but paid by you personally. You are responsible for coming to your session on time and at the time scheduled. If you are late your appointment will still need to end on time. Appointments are taken as confirmed at the time of verbal booking. Any reminders from Taryn Steyn serve as a courtesy and have no bearing on the confirmation of an appointment.

Professional Fees, medical aids, and administration
Consultations are charged at medical aid rates and are subject to annual increase. Although your medical aid may be paying, you remain responsible for payment of services rendered. It is your responsibility to familiarise yourself with the benefits, and terms and conditions of your medical aid.
The email address provided below will be used for correspondence related to your appointments and invoices. Should you not receive the related invoice within 5 working days after a session, you are responsible for ensuring that you follow-up and ensure that I do have a copy of the related invoice.
Accounts are handed over for legal debt recovery after 90 days. Any cost associated with such actions will be incurred by the person responsible for the account. This may result in having a bad credit record.
If you are not the medical aid's principal/main member you agree that the member is aware of the consultation and that they have given permission for the sessions to be claimed from your medical aid.

Professional records
I am required to keep appropriate records of the psychological services that I provide. Although psychotherapy often includes discussions of sensitive and a private nature, a very brief summary of the therapeutic themes and process will be noted. Your records will be maintained in a secure location.

Confidentiality
Therapy content is considered confidential. There are however legal exceptions to confidentiality which would include, but not limited to the following:

1 :: Should you disclose an intention to harm yourself or another person.
2 :: Should there be a suggestion that you are or have been involved in the abuse of a child or vulnerable adult.

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Initial please

3 :: Medical Aid and Third Parties (when applicable): Medical Aids and other third-party payers are given information that they request regarding service to clients. Information that may be requested includes the type of services, dates/time of services, diagnosis, treatment plan, and progress of therapy.
Finally, there are times when it is beneficial to consult with colleagues as part of my practice for mutual professional consultation. Your name and identifying details will not be disclosed.

Reports
This Practice does not deal with forensic assessments or court-related cases. Any reports, motivational letters, or forms requested will incur a fee which will be charged according to the duration of time spent on compiling the report.

Contacting me
If you need to contact me between sessions, or in an emergency, you have the right to a timely response. You may message or email and I will respond as soon as possible or by the next business day. If for an unforeseen reason you do not hear from me or I am unable to reach you, it remains your responsibility to take care of yourself until such time we can talk. If you feel unable to keep yourself safe, please go to your nearest hospital and ask to speak to the psychiatrist on call.

CONSENT TO PSYCHOTHERAPY
I, the undersigned, grant Taryn Steyn permission to treat myself or legal guardian in her capacity as a clinical psychologist. Your signature below indicates that you have read this Agreement and **AGREE** to its terms.

__________________________ __________________
Client Signature Date

____
Client Name (Print)

***In the case of a Minor**

________________________ __________________________
Father’s Name & Surname Mother’s Name & Surname

_________________________ ___________________________
Father’s Signature Mother’s Signature

_______________________ ___________________________
Date Date

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MEDICAL INFORMATION

1. PATIENT DETAILS

Surname	First Names Mr/Mrs/Miss
I.D Number	Occupation
Home Language	Marital Status
Cell	E-Mail

PERSON RESPONSIBLE FOR ACCOUNT

Surname	First name Mr/Mrs/Miss
I.D Number	
Home Address	
Postal Address	
Employer	
Cell	Email

MEDICAL AID

Name	Membership Number
Main member	I.D Number

NEXT OF KIN

Name	Relationship
cell	

This information will be used in cases of emergency. The practice may also contact this person if you are unreachable and your account remains unpaid

REFERRED BY

Name	Contact number

Medical History (Physical + Mental Health)

Diagnosis	Treating Physician	Medication + Dosage

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Initial please