Patient Registration Form

Practitioner: Gemma Gringlas

Patient Details

Given Name:		Surname:	
DOB:	Age:	Gender:	Preferred Name:
Address:			
Medicare No:		Ref No:	

Parent/Guardian 1

Given Name:	Surname:	
DOB:	Medicare:	Ref No:
Address:		
Phone:	Email:	
Relationship to patient:	Occupation:	

Parent/Guardian 2

Given Name:	Surname:	
DOB:	Medicare:	Ref No:
Address:		
Phone:	Email:	
Relationship to patient:	Occupation:	

Referring Doctor

Name:	Clinic:

GP (if different to above)

Name:	Clinic:

Paediatrician (if applicable)

Name:	Clinic:

School (if applicable)

Name:	Teacher:	Year Level:
Contact phone and email:		

Who is responsible for this account? Parent/Guardian/Agency:

Medical History/Reason for appointment:

Are there any court orders/custody arrangements for the child? ☐ YES ☐ NO

Medical/Allied Health services who have been/are involved with your child:

Diagnoses (Medical/Mental Health):

How did you hear about us?

Patient Registration Form
Practitioner: Gemma Gringlas

Are you concerned about your child in any of the following areas?

ACADEMICS	☐ YES	☐ NO	SOCIAL RELATIONSHIPS	☐ YES	☐ NO
PHYSICAL SKILLS	☐ YES	☐ NO	BEHAVIOUR	☐ YES	☐ NO
SELF CARE SKILLS	☐ YES	☐ NO	EMOTIONALLY	☐ YES	☐ NO
LANGUAGE SKILLS	☐ YES	☐ NO	INATTENTION/ENERGY/IMPULSIVITY	☐ YES	☐ NO

OTHER:

PRIVACY STATEMENT:
This medical practice collects information from you for the primary purpose for providing quality healthcare. We ask you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your healthcare needs. We may use the information you provide for administrative purposes in running our medical practice, including billing and compliance with Medicare and Health Insurance Commission requirements. Information may be sent to other practitioners involved in your care. Confidentiality will always be maintained if any information related to your care is used in research, quality assurance or educational purposes.

PAYMENT PROCEDURES:
All patients will receive an account for professional services rendered. Payment is required on the day of consultation. If eligible, your Medicare rebate will be claimed on the day. Please advise the receptionist if you are unable to pay your account on the day prior to your consultation. Patients who do not pay their account after consultation are advised that the payment is due strictly within 10 days. Accounts not paid within 10 days will incur additional fees.

I consent to the handling of my information by this practice for the purpose set out above. I understand my obligation with regards to payment of the account.

☐ I consent to the receive emails, newsletters, and marketing from Be Kids Therapy.

Parent | Guardian Signature: _____ Date: _____

Consent And Terms Of Service
Practitioner: Gemma Gringlas

CONFIDENTIALITY

Psychologists within this clinic are bound by the APS Code of Ethics regarding Confidentiality [Section A.5.2], as adopted by the Psychology Board of Australia. This states that client confidentiality must be maintained with the specific exceptions related to duty of care and legal obligation. Psychological therapy remains confidential unless permission is granted by the client to discuss information disclosed during therapy sessions

All personal information gathered by the psychologist during the provision of the psychological service will remain confidential and secure except where:
1. It is subpoenaed by a court; or
2. Failure to disclose the information could place you or another person at risk; or
3. Your prior approval has been obtained to:
a. Provide a written report to another professional or agency, including but not limited to other medical professionals or lawyers; or
b. Discuss the information with another person, e.g. parent/guardian or employer or if disclosure is otherwise required or authorized by law.

If you claim rebates from funding bodies, doctors and health practitioners, or like organisations, then your personal information may be required to provide summary reports to referring doctors, specialists and/or agencies regarding the client's progress.

INFORMATION SECURITY AND ACCESS

In the course of treatment, personal information is collected to enable treatment. All notes taken in the course of treatment and all communications relating to treatment form part of the client's clinical records. Clinical records are stored electronically in the client file on the practitioner's management software system, to which you consent. Client personal information is retained on the system for 7 years after ceasing engagement with your treating psychologist.

TERMS OF SERVICE

CONFIRMING APPOINTMENTS

Whilst we endeavour to confirm appointments via SMS or email, it remains your responsibility to be aware of the scheduled appointments.

TIME AND PUNCTUALITY

Unless otherwise advised, consultations are for a period of 50 minutes. If you are late, the consultation will normally finish at the scheduled end time.

CANCELLATION

48 hours' notice is required for all changes or cancellations by you. A cancellation fee of 50% of the consultation fee may apply if such notice is not received.

PAYMENT OF FEES

Unless otherwise agreed prior to the consultation, the full fee is payable on the day of consultation by credit card [VISA or MasterCard] or EFTPOS. We do not accept Diners or Amex cards. An account fee of $10 will apply for all accounts not paid on the day of consultation.

FEES

Consultation Fee: $260.00 per session
Assessment Consultation $520.00 (2 hours)
Assessment Report $900.00

MEDICARE CLAIMING If you have a mental health care plan, we will be able to submit your paid account to Medicare. Medicare will process the rebate within 48 hours and deposit the refund into your nominated bank account registered with them. It is your responsibility to keep record of the sessions used under the relevant Mental Health Care Plan and to provide a review from your referring doctor at the end of the six sessions.

AGREEMENT TO CONSENT TO SERVICES AND TERMS OF SERVICE

I hereby agree that I have read and understood the agreement to consent and terms of service as set out in this document and agree to these conditions for the psychological service provided by Gemma Gringlas, Clinical Psychologist.

Client [print name]:
Parent/Guardian Signature:

Parent/Guardian Name:
Date: