

CLIENT DETAILS

First Name _____
Surname _____
Telephone _____
Date of Birth _____

St Quentins Clinical Psychology
Suite 10/40 St Quentin Ave,
Claremont WA 6010

Neel le Roux
BA (Hons) MA (Clinical Psych)
Clinical Psychologist
Provider No: 2822583H
Reg. No: PSY0001578064
TEL 0423 767 573

PERSON TO BE CONTACTED IN AN EMERGENCY

Name _____
Telephone _____
Relationship _____

Halina Selwyn-Cross
BA (Hons) MA (Clinical Psych)
Clinical Psychologist
Provider No: 2822613W
Reg. No: PSY0001578065
TEL 0431 237 776

PERSON RESPONSIBLE FOR PAYMENT

| | | |
|----------------|----------|-----------|
| Title | Initials | Surname |
| Email | | Telephone |
| Postal Address | | |
| State | | Postcode |
| Home Address | | |
| State | | Postcode |

CLIENT INFORMATION

This is a private practice and fees charged are based on the schedule of fees endorsed by the Australian Psychological Society. Fees are reviewed annually at the beginning of each financial year.

Fees

Individual consultation \$254.00
Couple/Family Therapy..... \$254.00
The duration of each consultation is approximately fifty minutes.

Payment

Payment is due at the end of each consultation and can be made by cash or credit card. Receipts will be sent to you by email.

Rebates

Psychological services are covered by most private health funds and in some instances by Medicare. Please liaise directly with both you particular fund and Medicare in this regard.

Cancellations

A minimum of 24 hours notice is required to cancel or change an appointment.

Should this requirement not be met, the full consultation fee will apply in all instances as this practice elects not to assess the merits of each individual situation.

I confirm that I have read and understand the content in this form.

Signature _____

Date _____

CREDIT CARD DIRECT DEBIT AUTHORITY

I, _____ authorise Halina Selwyn-Cross/Neel le Roux until further written notice from me, to utilise my bankcard details as provided below and to draw from this nominated account the Practitioner's agreed fee at the end of each consultation.

This authority is also applicable to non-attendance or late cancellation fees.

Name on card _____

Card Number

Expiry Date _____ / _____ CCV/CVV Number

Signature _____

Date _____ / _____ / _____

Name of Client, if not the Card Holder _____