St Quentins
CLINICAL PSYCHOLOGY

CLIENT DETAILS

First Name

Surname

Telephone

Date of Birth

PERSON TO BE CONTACTED IN AN EMERGENCY

Name

Telephone

Relationship

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

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 reviewed annually at the beginning of each financial year.

Fees

Individual Psychotherapy (50min) $318.00

Couple Psychotherapy (60min). $354.00

Reports, Letters/Forms to Schools/Uni/
and Workplace ..... Pro Rata +gst

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

St Quentins
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ABN 94 914 057 356
Suite 10/40 St Quentin Ave, Claremont WA 6010
www.stquentinspsychology.com.au

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 _____

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