Robbie Pearman

Counselling Psychologist

HPCSA Reg. No.: PS0112640

Practice No.: 0398195

Cell: 079 925 2658

rdpearman@outlook.com

Block F, 10-12 7th Ave

Parktown North

2193

STRICTLY CONFIDENTIAL

Name: ______________________________ Surname: ______________________________

ID No.: ______________________________

Marital Status: ______________________________

No. of Dependants: ______________________________

Residential Address: ______________________________

____

____

Postal Address: ______________________________

____

____

Contact details: (H) ______________________________

(C) ______________________________

(email) ______________________________

Next of Kin -

Name: ______________________________

Relationship: ______________________________

Contact No.: ______________________________

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Referred by: ______________________________

General Practitioner/Psychiatrist -

Name: ______________________________

Contact No.: ______________________________

Medical Aid: ______________________________

Medical Aid No.: ______________________________

Main Member: ______________________________

Person Responsible for Account – *if not as above*

Name: ______________________________

Relationship: ______________________________

Contact no.: ______________________________

Email address: ______________________________

Please note that this practice is contracted out of Medical Aid schemes. You are personally responsible for payment after each session. You may then submit the invoice to your Medical Aid Society for reimbursement.

Please note that appointments not cancelled 24 hours in advance will be charged for at full rates.

Signed: ______________________________

Full name: ______________________________

Date: ______________________________

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The following serves as a contractual agreement for your therapeutic process.

Your signature indicates that:

a. The limitations of confidentiality have been explained to you.
b. That you agree to a “no suicide” contract during the course of your consultation with the therapist.
c. That you are responsible for all accounts.
d. That appointments not cancelled 24 hours in advance will be charged for at full rates.

I ______________________________ declare that I have understood and agree to this contract.

Signed: ________________________

Date: ________________________