

Patient Registration Form

- The details collected in this form are used by Leandie Buys to assist her to provide you with a counselling service. The information you provide to her is voluntary. If you do not want to share some of the details on this form, you may leave a blank space.
- All information is bound by strict confidentiality rules.
- Please complete all sections.

<p>Personal Details:</p> <p>Title:</p> <p>Surname:</p> <p>Given Name(s):</p> <p>ID No. Male:</p> <p>ID No. Female:</p> <p>Postal / Physical Address:</p> <p>Postal code:</p> <p>Work Details:</p> <p>Occupation:</p> <p>Employer:</p> <p>Work Address:</p> <p>Preferred Contact Details:</p> <p>Home:</p> <p>Work:</p> <p>Cell (Male):</p> <p>Cell (Female):</p> <p>Email:</p> <p>Details of Referring GP or other health care professional:</p> <p>Title & Initials:</p> <p>Surname:</p> <p>Telephone No.:</p> <p>Practice No.:</p>	<p>Additional Details:</p> <p>Have you been diagnosed with or do you suffer from: (Please tick boxes)</p> <p><input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Cardio Vascular Disease <input type="checkbox"/> Stress</p> <p><input type="checkbox"/> Headaches / Migraines <input type="checkbox"/> Diabetes</p> <p>Other:</p> <p>Are you on any medication:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please list medications and your condition here:</p> <p>How did you hear about Leandie Buys?</p> <p>Who referred you?</p> <p>Are there restrictions on how Leandie can contact you? (e.g.: not at work / only via email etc...)</p> <p>May Leandie leave a telephone message?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>May Leandie send you text messages?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you seeking therapy for:</p> <p><input type="checkbox"/> Relationship and Marriage</p> <p><input type="checkbox"/> Trauma</p> <p><input type="checkbox"/> Sex Addiction</p> <p><input type="checkbox"/> Other: Please specify _____</p> <p>_____</p> <p>_____</p>
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Confidentiality:

Confidentiality is an important part of any therapeutic relationship. As your therapist I, Leandie Buys, am bound by law to keep information confidential and secure. However, there are certain situations when information may not be kept confidential, which you should be aware of, as this may influence what you say during our sessions.

Information will not be kept confidential if:

1. Failure to disclose the information would put you or another person at risk
2. It is subpoenaed by a court
3. You have given me prior permission to:
 - a) Provide a written report to another professional e.g. GP or lawyer
 - b) Discuss the material with another person e.g. partner or parent

Please complete this section if you are on Medical Aid:

Medical Aid Scheme:

Membership Number:

Main Member Name:

Main Member Dependant Code:

Main Member ID N°:

Patient's Name:

Patient's Dependant Code:

Patient's ID N°:

Consultation Rates & Payments:

Timeslots of 90 minutes are allocated for each session, please refer to 'Consultation Rates for 2019' for more information regarding the rates.

Upfront payment is applicable to all clients **prior to each session** to confirm your appointment.

Fax proof of payment to 086-517 2107 or email to info@leandiebuys.co.za.

Practice banking details:

Leandie Buys; ABSA Bank; Cheque Acc. No.: 4067058424; Branch Code: 632005

Cancellation Policy: If you need to cancel or postpone an appointment, please advise me at least 48 hours before your scheduled appointment time to avoid being charged for your session.

Person responsible for account:

Name:

Tel:

I, (name here) have read and understood all of the above and agree to these conditions for the counselling service provided by Leandie Buys.

Signed:

Date: