Sne Makhathini
Counselling Psychologist
PS 0156329

INFORMATION FORM FOR INDIVIDUAL THERAPY

NAME: :_____

ADDRESS: RES. _____

POSTAL _____

TELEPHONE: (h) _____ (w) _____ (Cel.)_____

DATE OF BIRTH_____ AGE _____ MARITAL STATUS: _____

I.D. NO.:_____OCCUPATION: _____

WORK ADDRESS: _____

E MAIL ADRESS : _____

NEAREST FAMILY MEMBER/SPOUSE/ADULT CHILD/FRIEND TO CONTACT IN CASE OF EMERGENCY. **Please note that this person must give their permission for you to share their details for this purpose**.

NAME: _____

ADDRESS _____

OCCUPATION _____TEL No: _____ (work) _____ (home/cel)

MEDICAL AID : _____MEMBERSHIP No: _____

REFERRED BY : _____

FAMILY DOCTOR: _____

This practice charges according to medical aid rates once medical aid is approved. Fees are R950.00 per session for cash payment.

Please note that all missed appointments or appointments not cancelled 24 hours in advance are charged for at full rate.

I accept the above terms and undertake to pay all legal costs that may be incurred should I fail to settle this account as agreed. I accept ultimate responsibility for payment of this account even if I am a member of a medical aid.

I confirm that all the information provided is correct and accurate.

Signed _____ Date _____