Jonathan Bosworth

COUNSELLING PSYCHOLOGIST

BSc Hons (Wits) MA Couns Psych (Wits)

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PATIENT INFORMATION DOCUMENT

Dear Patient or Guardian

This document tells you exactly what you can expect from the therapy process and from me. It also explains what your responsibilities are. Please read it with care. It should not take more than 5 to 10 minutes. If there is something that you do not understand, please feel free to discuss this with me.

Evaluation phase

You and I may need between 1 and 3 sessions in order for us to evaluate whether we feel we can work together therapeutically. After this time, we may decide either to continue working together or perhaps that your specific needs may be better met by another therapist. In the case of the latter, I will be happy to provide you with an appropriate referral.

Therapeutic phase

Therapy usually brings about improved functioning and personal growth in the long term. In the short term, however, it may be an unsettling experience, as it is usually an emotional experience. Some temporary emotional distress is possible. This may have a negative influence on your studies or work, as well as your social and personal functioning for a period of time. Successful therapy may sometimes have 'negative' consequences in the long run. The purpose of therapy is to bring about change. As a result, clients sometimes feel that they should make changes in their circumstances as well. This may specifically induce you to bring about changes in your relationships with others. Such changes are not always welcomed by those affected and this may lead to interpersonal tension.

Confidentiality

1. All private information collected about you in the course of therapy will be treated as highly confidential. Subject to what is said in paragraph 2 (below), no information about you will be disclosed without your consent.
2. In certain exceptional circumstances, however, legal or professional rules may force me to disclose information about you. This will include:
2.1. *Emergency situations*
In this regard I want you to know that should a situation develop where I believe that there is a real risk that you may harm yourself, another person, or myself, I will be compelled to take the necessary steps to prevent such harm, even if this may entail my breaching my promise to keep your information confidential.
2.2. *Statutory duty*
A provision in a legal act may oblige me to disclose confidential information about you.
2.3. *Court orders*
A court may order me to disclose private information. In terms of my professional rules I must, however, endeavour to do everything possible to prevent the disclosure of your private information.
3. That which I have pointed out in paragraphs 1 and 2 above is also applicable in respect of children under the age of 18. I will on a regular basis inform parents or guardians about the therapeutic process and the progress of the client. As a general rule, no information will be given to a parent or guardian about the content of a session without the relevant client's consent. I do, however, reserve the right to inform a parent or guardian if it appears that the relevant child makes him or herself guilty of criminal behaviour, or threatens with, or is involved in behaviour that I consider to be dangerous or potentially dangerous.
4. Medical Aids require an International Classification of Diseases and Health Problems Code (ICD 10 Code). Please note that this code is required to be given on your statements for your medical aid.

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5. In order to offer a professional service, I will sometimes discuss and write up cases and academic material with a suitable senior colleague. I will avoid using any identifying details. The psychologists concerned are qualified professionals who treat information as confidential.

Fees

1. I charge the fees recommended by the National Health Reference Price List as published by the National Department of Health and in line with current medical aid rates.
2. In accordance with this, the amount agreed upon by ourselves is **R**_____ per session.
3. If the person who I will be attending to (the "client") does not accept responsibility for payment of my account, the name and other particulars of the person who does accept responsibility, must be indicated below.
4. Should you not be able to keep an appointment, you must please cancel it. If you fail to do so more than 24 hours in advance, the person responsible for the payment of the account will be held liable for payment of the full amount for a session.
5. I work on an appointment basis and as such will not be able to exceed the time allocated for a session. Sessions are 50 minutes in duration. Should you arrive late for a session, the session will be shorter and still end at the usual time. The person responsible for the payment of the account will be liable to pay the full session fee.
6. Accounts must be paid within 7 days after receipt of invoice. We agree upon ourselves for me to provide you with a **weekly/monthly** (circle appropriate option) invoice.
7. I require fees to be paid by cash or electronic transfer (EFT). The Medical Aid member may claim back therapy fees from the Medical Aid Fund after payment has been made to me.
8. No relaxation or amendment of these rules will be binding unless recorded in writing.
9. If I am forced to hand an outstanding account to an attorney for collection, the person responsible for the payment thereof will be liable to pay any legal costs incurred.

Termination

Either you, or myself, can terminate therapy at any stage (subject to what is stated about cancellations). I will only terminate therapy in consultation with you and in a professionally accountable way.

Forensic Work

I do not offer services for forensic purposes. As abovementioned, I will only participate in legal proceedings if I have been instructed to do so by court order.

Responsibility

The responsibility for all decisions taken in your life still lie solely with you, and I will not accept responsibility for your actions.

Please do not hesitate to discuss any of the above information with me should you require further clarity.

I agree to all the terms and conditions stated herein:

Patient name: _____
Signature of patient or guardian (in the case of minors): _____
Date: _____

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If applicable:

Person responsible for the account (if someone other than the patient)
Name: _____
Signature: _____
Date: _____