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***Leisa Roder***

***Provider No. 4503154B***

***AHPRA No: PSY0000953169***

***Tracey Bailey***

***Provider No. 4994784L***

***AHPRA No: PSY0001753672***

Psychology

Enhanced **Psychology**

***Leisa Roder 4593153T***

***AHPRA No: PSY0000953169***

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**SERVICE AGREEMENT**



***(1) Privacy and confidentiality***

The law gives you certain privacy rights in relation to the information that you give this practice. We need your consent to collect personal information about you or your child/ren. This section of the form explains your rights, how we use that information and how it may be disclosed to medical service providers and in specific circumstances, other persons or agencies.

When treating children, the psychologist may discuss session information with parents, carers or third parties, if appropriate.

The main reason we collect information from you is so we can assess, diagnose and provide you with appropriate services. The information you provide will also be used in the following ways:

* Administration of this psychology practice;
* Billing, including compliance with Medicare and Health Insurance Commission requirements;
* Disclosure to others involved in your care, including doctors, specialists and mental health practitioners who may become involved in treating you. This may occur through a referral to doctors or services, or for medical tests and in the reports or results returned to us following the referrals. If necessary, we will discuss this with you;
* Disclosure to others to whom your prior written consent has been obtained (you are required to endorse a Release of Information Form) to:
	+ Provide a written report to another professional or agency (e.g. general practitioner) or to
	+ Discuss the material with another person (e.g. a carer or employer)
* Disclosure when required or authorised by law and to others for malpractice defense purposes;
* Disclosure to others when the information you provide indicates that you or the community are at risk of harm to self or others.

You may access the material recorded in your file upon request, subject to the exceptions in National Privacy Principal 6.



***(2) Fees***

The cost of consultations is determined by their length and place of service. *Fees are payable by EFTPOS at the end of the consultation.* No cash is kept on the premises. Clients referred by their general practitioner with a mental health care plan are eligible for a Medicare rebate.

***(3) Cancellation policy***

If you cancel or reschedule an appointment, please give at least 24 (business hours) notice. A $50 fee will apply if you do not attend or fail to cancel your appointment within 24 hours of the appointment. Non-attendance fees must be paid in full prior to additional appointments being made. Future appointments may be refused if you do not attend booked appointments.

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***(4) Disclosure (parenting orders/information accessible to other parent/carer)***

It is the responsibility of the parent attending the sessions with the child/ren to inform the other parent about the sessions as per their individual parenting orders. If appropriate, the other parent is welcome to attend individual sessions (in relation to the child). Please disclose any issues pertaining to custody, ie restrictive orders, domestic violence, custody or court orders.

***(5) Reports, correspondence and assessments***

Please note we do not provide letters for Centrelink, court or custody matters. Requests for reports, correspondence and assessments will require approval prior to completion and may be subject to a timeframe of 6-8 weeks following the collection of all necessary data. Fees may apply and will be quoted upon application.

***(6) Pets on premises***

No pets or animals are allowed on the premises.

***(7) Client and/or parent acknowledgment***

I have read this form and understood why collecting information about me or my child is necessary. I am also aware that *Enhanced Psychology* has a privacy policy on handling client information.

I understand that I am not obliged to provide any information requested of me. I also understand that failure to provide the treating psychologist with all the information she/he needs, may restrict his/her ability to provide the quality of treatment and service that I want.

I am aware that I have the right to access the information collected about me or my child, except in some circumstances where access might legitimately be withheld.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure about which I notify this practice now or at any future time.

I agree to the above conditions for the provision of psychological services and understand this document will be placed on my file and is able to be viewed at any time.

I acknowledge that I have read this form before signing it and that a member of the staff of this practice has at my request, clarified any aspects of it that I did not at first understand.

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ***(Please print CLIENT name in full)***

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ***(Client or Parent Signature)***