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**Terms and Conditions of the Practice of Dr Jenny Rose (Pty) Ltd**

By signing this form, I acknowledge that I have understood and agreed to the following:

* That I have received a copy of the terms and conditions (provided separately) and have had an opportunity to ask questions on aspects thereof that I was uncertain about.
* I acknowledge that if I am uncertain regarding any aspect of the processes, consents, policies and / or forms, I will clarify this with the practice.
* If I do not keep my appointment and I have not cancelled the appointment 24 hours prior to the appointment, the practice reserves the right to charge a full consultation fee, regardless of the reason for the cancellation.
* If I am unable to reach the practice telephonically to cancel my appointment I acknowledge that I am encouraged to send written communication about my wish to cancel the appointment via either email or text. Communication received via such mediums within the cancellation period, whether read and confirmed or not by the practice will suffice as cancellation.

**Informed Consent for Psychological Evaluation and Treatment**

**Confidentiality**

* I understand that all information regarding me will be treated as medically confidential.
* I understand that confidentiality is legally required to be breeched in instances where I prove to be in danger of harming myself, another human being or animal; in cases of apparent, suspected or potential child abuse or neglect; or in cases where a court issues a summons for records or testimony.
* Dr Jenny Rose and associates may use forms of communication, such as messages or emails, which despite all efforts to maintain confidentiality, may not be guaranteed due to the nature of technology.
* In the event that family members or other individuals make contact with the practice or psychologist / associates requesting information or meeting concerning me (the client), all prescribed limits of confidentiality will be adhered to in accordance with the Health Professions Council of South Africa (HPCSA) and in accordance with the POPI Act. This means that neither the psychologist nor practice associates will disclose any details whatsoever regarding me, my sessions or my therapeutic content. I am in my rights to request and consent to a family session, which will only take place if I am present in that session.
* The practice / psychologist / associates will only communicate with me directly and not with an individual on my behalf unless I provide the practice with my written consent to communicate with a specific indicated person. Such consent would be required to specifically indicate the individual who can be communicated with, duration that such communication is required and specifications about the content that may be discussed with such an individual.

**Client Records**

* I acknowledge that client records are kept for a period of 6 years from the date of last consultation or as regulated by professional standards set out by the HPCSA and in accordance with the POPI Act.
* I acknowledge that I am a client of Dr Jenny Rose (Pty) Ltd and not of my assigned treating psychologist / associate and therefore my client records remain property of this practice for the duration as set out as above. In the event that my treating psychologist / associate may exit the practice, a request for the transference of my personal information may be applied for in accordance with PAIA regulations.

**Supervision & Multi-professional Teams**

* Any psychological and social information regarding me may, with my permission, be discussed with a relevant multi-professional team.
* My information may be discussed with relevant parties for the purpose of supervision, within a confidential setting, to enable my psychologist / associates to provide me with improved therapeutic strategies.
* I am aware that my psychologist / associate, although fully qualified and registered, may be continuously taking on additional training to increase competency and therefore may also be receiving training within the practice.
* In the event that my treating psychologist / associate is no longer an employee of this practice, my therapeutic information may be accessed by management of this practice and my new treating psychologist / associate in order to allow for continuation of treatment. In such an event all efforts will be made to maintain confidentiality and limit shared information.

**Therapeutic Treatment**

* I acknowledge that psychological treatment will only be provided in the capacity as agreed upon between the relevant parties. I am aware that a psychologist / associate may not overlap between working in a legal capacity and a therapeutic capacity. This would mean that my psychologist / associate treating me in a therapeutic capacity cannot provide me with a report for whatsoever legal purposes.
* During my continuous sessions myself and my psychologist / associates will agree upon a treatment plan, which may be adapted and changed during the therapeutic process. I hereby consent to ensure that I understand the treatment plan, risks and benefits of my therapeutic processes. Thereby agreeing to release the practice of Dr Jenny Rose (Pty) Ltd and its associates, to the extent permitted by law, from all claims for any loss or damages suffered as a result of the treatment.
* I hereby state that I have taken note of my treating psychologist’s / associate’s qualifications and training and I consider him/her a suitably qualified person to treat me.

**Reports**

* In order for any reports, letters, medical aid or other applications to be disclosed, a consent for disclosure application needs to be completed as per the POPI Act and PAIA regulations as any such report, letter or application will contain my personal information.
* A relevant psychological report about me may be submitted to applicable parties if proved necessary, with my knowledge and permission.
* A report will not be provided for legal purposes of whatsoever nature if the purpose of treatment is not of a legal nature and has not been agreed upon on commencement of therapeutic treatment.

**Billing Administration & Medical Aid Claims**

* I am aware that in the event of claiming through medical aid, the psychologist / associate will need to include an ICD-10 code on my invoice, which will give the medical aid an indication of the condition that I am being treated for. I have the full right to know what this code will be and discuss this further with my psychologist / associate. If I refuse for this information to be submitted as a claim to my medical aid, I will be liable for the payment of my sessions based on the card rate of the practice.
* I understand that submitting to medical aid is my own responsibility, and I am liable to settle the invoice directly with the practice within 48 hours of date of invoice.
* I am aware that in the event of submitting a claim through medical aid the medical aid may request additional information as per their terms and conditions.

* I authorise the practice to process my personal information in order to perform their services. Including the relevant release of any of my clinical information such as diagnostic code and other information required to process my invoices in order to submit claims or to collect outstanding balances on overdue accounts.
* I understand that Dr Jenny rose (Pty) Ltd make use of the services of administrative staff, who are bound by the confidentiality agreement of the practice, and thereby agree that my personal administrative, account and communicative information may be disclosed to such staff members.
* By submitting my claim to my medical aid I understand that this may mean that other members/ beneficiaries on my medical aid scheme may have access to information pertaining to my session or claim once this is submitted regardless of measures taken by the practice to protect my personal information.

**Children**

* Children over the age of 14 years are required to give therapeutic consent and are entitled to the same confidentiality as that as an adult. This would mean that the treating psychologist / associate may not disclose any therapeutic information to another party if the child has not given their consent for the psychologist to do so. As the parent or legal guardian of the child patient I acknowledge this confidentiality agreement. Parental consent for therapy is not legally required.
* For children under the age of 14 years to attend therapy, consent from both parents is required, except in cases where one parent can prove that he/she has full legal custody of the child. We would require that both parents sign forms which will provide consent for the child to attend therapy. Therapy cannot commence until we have received consent from both parents.

* The psychologist / associate will discuss the plan and structure regarding feedback on my child’s therapeutic process. The psychologist / associate may not be available for feedback outside of the agreed upon structure, and I understand the limitations of my psychologist’s / associate’s time as he/she may be attending to other clients and work hours are appreciated. For any communication regarding my child’s treatment, emails are preferred.
* Although my child might be over the age of 14 and is required to give therapeutic consent as per clause a), in accordance with the POPI act a legal parent or guardian would be required to give consent for non- therapeutic gathering and disclosure of information.
* As a parent, I give permission for my treating psychologist / associate to liaise with my child’s school and his / her teachers, in order to provide collateral information and insight into their functioning.

**Inpatient Treatment**

* I acknowledge that if I am treated at an inpatient facility or hospital that my confidentiality will be maintained, and with my permission discussions can be held with multidisciplinary treating practitioners.

**Sessions via Technology**

* In the event that I choose to attend therapy using a form of technology such as Zoom, Skype, Facetime, WhatsApp calls, video calls, or via a phone call, I understand that my psychologist / associate will schedule an appointment time with me and will provide such a service in a confidential setting and provide the service to the best of his/her capabilities. I acknowledge that potential technical difficulties may be experienced, and Dr Jenny Rose (Pty) Ltd will not be held liable for diminished levels of service due to such technical factors.
* In the event that I require therapy using a form of technology as stated above I would be responsible for ensuring that I am in a confidential setting within which the session would be conducted.
* My psychologist / associate reserves the right to terminate sessions in the event that my environment in not confidential, in accordance with the POPI Act and HPCSA regulations this will be done to protect my personal information and confidentiality.

* I will be responsible for ensuring that the application and any required software is downloaded and that I have access to the telehealth platform. Please be aware that clients are responsible for any costs incurred in relation to the provision of their own software, hardware and data usage associated with telehealth services.
* Telehealth services requires clients to have a secure WIFI or internet connection and a working webcam and audio on their device.
* Clients should be aware that misunderstandings may occur due to connection problems causing image delays or less than optimal image quality. Teleconferencing generally limits the amount of non-verbal information exchanged between the treating psychologist / associate and clients and as a result, misunderstandings may occur. Clients are asked to please have patience with the process and clarify information if they think their treating psychologist has not understood them well and to also be patient if their treating psychologist / associate asks for periodic clarification.
* In case of emergency my treating psychologist may need to be able to contact support people known to me within me local area. Accordingly, clients will be asked to provide the names and contact details of two people known to them before the initial session. By providing my psychologist / associate and the practice with the contact details of such individuals, I acknowledge that I have gained their consent to share their information with us.

* The privacy of any form of communication via the internet is potentially vulnerable and limited by the security of the technology. Clients are responsible for understanding the potential risks of confidentiality being breached through unencrypted email, in transit by hackers or internet service providers, lack of password protection or leaving information on a public access computer. My treating psychologist / associate will make every effort to keep all information confidential. Likewise, clients are asked to take responsibility for creating and using additional safeguards when the computer used to access telehealth services may be accessed by others, such as creating passwords to use the computer, keeping email and passwords secret, ensuring they fully exit all online therapy sessions and email, and maintaining security of their wireless internet access points. This applies to all online courses purchased through the Dr Jenny Rose (Pty) Ltd website.
* I acknowledge that any online courses purchased through the Dr Jenny Rose (Pty) Ltd website are not a substitute for therapeutic services offered by psychologists or psychiatrists or any other mental health care practitioner.

**Communication with the Practice or Psychologist**

* Any communication with my psychologist / associate between sessions or management of the practice needs to be made via email for the purpose of record keeping. My psychologist / associate may not be available to consult with me telephonically between sessions.
* Records of electronic communication will be kept only for the reasonable duration in relation to the purpose of the communication.
* I acknowledge that my psychologist / associate / management of the practice may not be able to respond to my email timeously due to the consultation nature of the practice.

**Rates**

* Rates are standardised as of January of each year, regardless of medical aid rates. Depending on your medical aid, there may be a co-payment applicable. Rates can be made available upon request. Please not that rates are increased at the start of each year.

**Payment & General Terms of the Practice**

* By using the services of the psychologist / associate, you confirm that you accept the following payment terms:

**Medical Aid Claims**

* If I am not the principle/main member of my medical aid, I agree that the principle/main member is aware of the consultation and that they have given permission for the psychological sessions to be claimed from medical aid.
* This practice is a cash practice. This means that invoices are submitted directly to the client, who is liable for the invoice. The client then sends the claim to their respective medical aid.
* Some medical aids require pre-authorisation and/or motivation prior to treatment. Pre- authorisation or scheme approval is, according to the medical aid, no guarantee of payment. I understand that I am responsible for obtaining pre-authorisations for sessions and for providing the practice with the relevant information and documentation.
* It remains my responsibility, and not that of the practice, to familiarise myself with the benefits and terms and conditions associated with my chosen medical cover.

* Should there be a shortfall in medical aid funds, or the funds become depleted, the person whose signature appears on this document will be held responsible for any outstanding amounts unless a signed letter is received from the individual listed under person responsible for account. You will be notified by the Accounts Department of Dr Jenny Rose (Pty) Ltd regarding any outstanding amounts.
* I acknowledge that I am responsible, and not the staff of the practice, to resolve any queries I may have regarding my account with Dr Jenny Rose (Pty) Ltd with my medical aid.
* Dr Jenny Rose (Pty) Ltd cannot be held responsible for any errors or incorrect use of funds made by your medical aid.
* In the event that there is a query regarding payment of my medical aid, I give the practice permission to contact my medical aid to resolve such an issue on my behalf, and in doing so consent to the practice sharing my personal information with the contact person at my medical aid.

* If I feel that my medical aid scheme should have paid my account in full, I can lay a complaint at the Council for Medical Schemes by emailing them at complaints@medicalschemes.com.

**Payment Terms**

* I am responsible for any outstanding amounts on the account, including amounts not paid by a medical aid claim and any co-payments that may apply.
* Any payments made via EFT needs to contain my full name as reference in order to allocate my payment to my account. I acknowledge that this reference may reflect on the practice bank statements, banking profile, and payment notifications receive. In the event that I provide my name as reference, I am consenting to this personal information being disclosed in instances where such banking documentation may be shared or required by third parties.
* In the event that an EFT payment is made for a session, that payment needs to be made at the time of my scheduled session, and POP sent to my psychologist’s / associate’s email address with my name as the reference.
* No Cheques, Diners Club Cards or American Express Cards are accepted as methods of payment.
* Refunds will not be made for incorrectly paid or pre-paid amounts, whether due to medical aid or private error, and will remain as credit on your account.
* Clients are encouraged to approach the practice immediately if they experience problems with the payment of the account.

* Accounts are handed over for legal debt recovery after 90 days. Any costs associated with such actions will be incurred towards the person responsible for account. This may result in having a bad credit record.
* As the adult client I will be the recipient of statements and other communication from the practice. If another individual is elected to receive statements and communication, we require this to be requested in writing with both the client and elected statement recipient to give consent for this request.
* If the client is a minor (under 18 years of age) the parent that has signed this form will be the statement and communication recipient unless written consent is received from the elected statement recipient.

**PMB (Prescribed Minimum Benefits)**

* Certain conditions may be covered by my medical aid with PMBs (prescribed minimum benefits) and my psychologist / associate may apply for this on my request. If I have medical aid benefits and funds available, my sessions will be claimed as a normal medical aid claim until approval for my PMB application is received and approved by the medical aid. In the event that I do not have medical aid benefits or funds available I will be responsible for the payment of I sessions until approval for my PMB application is received.
* Applications submitted for PMBs or other benefits does not guarantee approval of such, and I remain responsible for the payment of sessions during the application process.
* I, and not my psychologist nor the practice, remain responsible for understanding my medical aid PMB benefits, how my medical aid and specific plan assign these benefits and the medical aids conditions of payment or other conditions my medical aid may have of such benefits.
* In the event that my medical aid approves PMB benefits, I and not my psychologist, nor the practice, remain responsible for ensuring that I have PMB sessions remaining from which my sessions will be claimed from. In the event that I have run out of the number of approved PMB sessions, I will be responsible for settling sessions privately.

* In the event that my medical aid approves joint PMB benefits for psychology and psychiatry, I remain responsible to be informed of how many of PMB sessions I have remaining.
* I acknowledge that my medical aid may require that I reapply for PMB benefits every year, regardless of whether I had sessions remaining for the previous calendar year.
* It remains my responsibility to be aware of any implications that a PMB application may have. Examples of such implications may be limitations to insurance applications.

**Sessions via Technology**

* In the event that I request a session using a form of technology; I will be responsible for the payment, and such a payment needs to be made at the time of my scheduled session, and proof of payment emailed to Dr Jenny Rose (Pty) Ltd at my psychologist’s email address with my name as reference.
* In the event that I have outstanding fees from previous sessions, the practice reserves the right to postpone any future dated sessions up until such a time after which my payment has been received.

**Forex Payments**

* Any payments made to Dr Jenny Rose (Pty) Ltd in foreign currency will be charged inclusively of the additional forex bank charge. I will therefore be responsible for the session rate, as well as any additional costs associated with the forex payment.

T**hird Party Payments**

* Dr Jenny Rose (Pty) Ltd will not accept payment from a third party (such as a company or an individual paying on behalf of another) without a written, signed letter from the third party stating the number of sessions that they have agreed to, what their expectations of the sessions would be (such as report) and a commitment to pay following each session or ahead of each session. Additional charges may occur due to report writing or administrative tasks that are linked to such payments. Including and not restricted to the costs incurred and time required to acquire requested documentation.
* Dr Jenny Rose (Pty) Ltd will not be involved in any payment agreements between parties for whatsoever reason.
* Dr Jenny Rose (Pty) Ltd has the right to charge for any additional documentation and the time spent acquiring such requests by a third party due to documentation requirements, in order to receive payment.

**Reports, Letters and Assessments**

* Any reports, motivational letters or forms requested will incur a fee which will be charged for according to the duration spent on compiling the report. These charges will be payable according to our card rates and not claimed through my medical aid.
* I will be required to provide written consent for any reports, letters or forms requested to be sent by the practice by completing the required consent form in accordance with the POPI and PAIA Act.

**Termination of Therapeutic Services**

* If my account has any outstanding amounts the practice may elect to pause or stop providing therapeutic services due to non-payment, and therapeutic services may be resumed once full outstanding payment is received.
* The practice or my psychologist may elect to terminate therapeutic services in the event that my account is not paid.

**Complaints and Compliments Policy**

* I am requested to address any concerns or complaints at the time that such concerns or complaints arise directly with either the administrative staff at the practice or with my treating psychologist / associate.

**Protection of Personal Information Act (POPI)**

* The practice will collect, treat and store my personal information for the purposes of providing therapeutic services and for billing reasons. All information is processed in a reasonable and relevant manner, as well as treated with confidentiality and in line with the POPI Act.
* In order to keep my information up to date, I will supply the practice administrative staff or my treating practitioner with my latest contact detail and ask for deletion of any information I no longer want held by the practice.
* Clients have a right to any documentation held by the practice containing their personal information. If a client wishes to request specific information held by the practice I are required to submit an application form as per the PAIA policy. The practice reserves the right to approve or deny applications.
* All attempts have been made to ensure that our procedures around, systems used and mediums of providing our therapeutic services are POPI compliant.

* Our Privacy Policy and all relevant POPI Act documentation is available on request which outlines the various legalisation and processes and policies that we follow.
* In the event that there is a breach of my Personal Information in accordance with both HPCSA and the POPI Act, I will be contacted and informed of such in accordance with the guidelines set out by the above-mentioned regulatory bodies.

*Please note that the terms and conditions of service are updated on a regular basis and by continuing with therapy I consent to the terms and conditions of the Practice. If you would like a copy of the terms and conditions at any stage, please enquire at reception or visit our website.*

DATED at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on this \_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_\_.

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Client Signature