Intake Form New Patient / Inname Vorm: Nuwe Pasiënt

A. PERSON RESPONSIBLE FOR ACCOUNT / PERSOON VERANTWOORDELIK VIR REKENING

Full names / Volle name: _____

Surname / Van: _____

ID number (main member of medical aid) / (hooflid van mediese fonds): _____

Address / Adres: _____ Code / Kode: _____

Tel: _____ Email / E-pos: _____

Employer / Werkgewer: _____

B. PATIENT PARTICULARS / PASIËNT BESONDERHEDE

Full names / Volle name: _____ Surname / Van: _____

ID number/Date of birth / ID nommer/geboortedatum:_____

Address / Adres: _____ Code / Kode: _____

Tel: _____ Email / E-pos: _____

Medical Practitioner's Name: _____

Medical Practitioner's Telephone Number: _____

C. NEXT OF KIN / NAASBESTAANDE

Full names and surname / Volle name en van: _____

Address / Adres: _____ Code / Kode: _____

Tel: _____ Email / E-pos: _____

D. MEDICAL AID DETAILS / MEDIESE FONDS BESONDERHEDE

Name of medical aid / Naam van mediese fonds: _____

Option / Opsie: _____

Medical Aid number / Mediese fonds nommer: _____

Main member (Name and ID) / Hooflid (Naam en ID): _____

Dependants on medical aid / Afhanklikes op mediese fonds:

Name / Naam	Date of birth / Geboortedatum	Gender

Consent And Agreements / Toestemming En Ooreenkomste

1. **Cancellation / Kansellasie:** Appointments cancelled less than 24 hours in advance or missed without notice will be charged in full. Medical aids do not cover these charges, and the outstanding amount will remain the patient's responsibility.
2. **Fees / Fooie:** The psychologist is contracted with medical aids and charges medical aid rates. If paying privately via cash, credit card, or EFT, the standard consultation fee applies. For the most up-to-date fee structure, please visit cornepeach.co.za.
3. **Confidentiality / Vertroulikheid:** All consultations are confidential. However, in specific situations where a patient's safety or the safety of others is at risk—such as suicide ideation, self-harm, or threats to others—the psychologist is ethically and legally required to break confidentiality. In such cases, relevant professionals, a nominated medical practitioner, or a designated family member/friend may be contacted.
4. **Medical Aid Claims / Mediese Fonds Eise:** In accordance with medical aid requirements, the psychologist must provide a diagnostic code (ICD-10 code) for claims to be processed. For PMB (Prescribed Minimum Benefit) applications, medical aids require an ICD-10 code along with a brief motivation. By signing this agreement, the patient consents to the disclosure of this information to the medical aid scheme.
5. **Legal Costs / Regskoste:** Should any outstanding fees require legal action, the patient agrees to cover all associated costs, including tracing, collection, and legal fees.
6. **Liability / Aanspreeklikheid:** The psychologist is not responsible for any injury, loss, or damage to the patient, their family members, or their property, including their vehicle, while attending sessions.
7. **Termination / Beëindiging:** The psychologist reserves the right to terminate therapy if it is deemed in the patient's best interest. In such cases, a referral to an appropriate professional or therapist will be provided.

Declaration

I _____confirm that the information provided is accurate and that I have read, understood, and agree to the terms outlined above. I acknowledge that the psychologist may charge the full consultation fee for appointments cancelled less than 24 hours in advance or for missed appointments. I understand that medical aids do not cover late cancellations or missed sessions, and I accept personal responsibility for any outstanding fees.

Signature: _____ Date: _____

Clinical Psychologist: Corné Peach
HOD(Pret) BA Psych(Hons)(Pret) M.A. Psych(Clin)(Unisa) **Registration number:** PS0070912
Practice number: 0033006

Consent to Disclosure of Information & Fees Agreement

1. Purpose of This Document

This document outlines your consent to the collection, processing, and disclosure of personal information in accordance with the Protection of Personal Information Act (POPIA) and other applicable healthcare regulations. It also includes agreement on fees and financial responsibility.

2. Collection and Processing of Personal Information

Types of Information Collected

We collect and process the following personal information to provide psychological services, maintain treatment records, and process medical aid claims:

- Personal identifiers (name, ID number, contact details)
- Medical aid details
- Health and medical history
- Treatment records
- Financial information related to billing

How Your Information Is Stored and Secured

Your records are securely stored and maintained for a minimum of six years or as required by relevant healthcare laws:

- **Physical records**: Kept in locked cabinets within secure home and/or office premises.
- **Electronic records**:
    - Stored on password-protected, encrypted systems.
    - Secure cloud storage services compliant with POPIA and international data protection standards.
- **Security measures include**:
    - Access control to physical premises.
    - Encryption of electronic data.
    - Regular security updates and backups.
    - Secure disposal of records when retention periods expire.

3. Disclosure of Information

Your personal information may be disclosed under the following circumstances:

A. Required Disclosures

- **Healthcare Providers**: Attending and referring practitioners may request relevant clinical information.
- **Medical Aid Administrators**: Submission of ICD-10 codes, diagnoses, and prescribed medications as required by the Medical Schemes Act.
- **Employer or Institutions**: Sick leave certificates may be issued, indicating days off but without disclosing ICD-10 codes.

B. Third Parties Who May Process Your Data

Your personal information may be shared with the following third parties to facilitate

your care and administrative processes Medical aid schemes for claims processing.

- Medical aid schemes – for claims processing.
- Healthcare providers – involved in your care.
- Practice management software providers – to manage appointments, billing, and records.
- Cloud storage providers – for secure electronic record-keeping.
- IT service providers – responsible for maintaining our systems.
- Insurance companies – with the patient's consent, for the completion of psychological wellness questionnaires required for insurance purposes.

All third parties are bound by:

- Confidentiality agreements.
- Data processing agreements compliant with POPIA.
- Professional codes of conduct and healthcare legislation.

C. Additional Authorised Recipients

You may authorise additional individuals to receive specific information about your treatment.

Name & Surname:

_____

Relationship:

_____

D. Your Rights Under POPIA

You have the right to:

- Request access to your personal information.
- Request correction of incorrect or incomplete data.
- Object to the processing of your information.
- Lodge a complaint with the Information Regulator.
- Be notified in case of a data breach.

Information Officer: Corné Peach
Contact: cpeach@mweb.co.za

4. Fees & Financial Responsibility

- The psychologist is contracted with medical aids and charges medical aid rates.
- If paying privately via cash, credit card, or EFT, the standard consultation fee applies.
- For the most up-to-date fees, please visit cornepeach.co.za or enquire directly.
- Appointments cancelled less than 24 hours in advance, or missed without notice, will be charged in full. Medical aids do not cover these charges, and the outstanding amount remains the patient's responsibility.
- Unpaid accounts may be subject to debt recovery, and the patient will be liable for all associated legal and collection costs.

5. Declaration & Signature

I confirm that I have read, understood, and accept the terms outlined in this document. I acknowledge my rights under POPIA and accept financial responsibility for services rendered.

Clinical Psychologist: Corné Peach
HOD(Pret) BA Psych(Hons)(Pret) M.A. Psych(Clin)(Unisa) **Registration number:** PS0070912
Practice number: 0033006

Patient's Name: _____
Signature: _____
Date: _____

Witness Name: Corné Peach
Witness Signature: _____
Date: _____

TO BE COMPLETED BY THE PATIENT

Patient Health Questionnaire (PHQ-9) [1,5]

Patient Name:_____ Date:_____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

*This leaflet ONS PHQ-9 is produced solely for informational purposes by Aspen.
Please note that any information you provide, on this questionnaire, to your health care professional does not revert to Aspen.

Adapted from Kroenke K, *et al.*[1] and Robert L, *et al.*[5]

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