+27 72 284 7793
admin@theprivatepracticesa.co.za
ThePrivatePracticeSA.co.za
Suite 101, Wrenrose Court,
64 St Andrews Street, Birdhaven

INFORMED CONSENT FORM AS PER HPCSA REGULATIONS

PSYCHOLOGIST - CLIENT SERVICE AGREEMENT

1. YOUR RIGHTS AND THE PRIVATE PRACTICE POLICIES

This document contains important information about my professional services and business policies. When you sign this document, it will represent an agreement between us.
We can discuss any questions you have when you sign the document or at any time in the future.
Kindly complete and sign this document namely:

- Informed consent form
- Telepsychology informed consent form
- POPIA document

2. PATIENT INFORMATION

Name and surname: _____
Date of birth: _____
ID: _____
Cell number: _____
Email address: _____
Occupation: _____
Physical Address: _____
_____
_____
Emergency contact Name: _____
Emergency contact number: _____

Medical aid details:

Name of medical aid: _____
Medical aid number: _____
Name of main member: _____
Main member ID: _____

Your signature below indicates that you have read this Agreement and agree to the terms.

Signature: _____

Date: _____

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3. FEES AND PAYMENT

Medical aid tariffs apply.
I charge the average benefit for therapy, across all medical aid schemes (50 to 60 minutes per session). I am registered with the major medical aids. If your medical aid is not on our list that we are registered with, you are responsible for paying on the day of the appointment (EFT or direct payment via Yoco).

As part of therapy, we will agree on practical focus areas and tasks to work on between sessions. In addition to in-session work, I offer post-session treatment support, which may include brief written summaries of agreed tasks, structured reflections, or short follow-up clarification between sessions where clinically appropriate. This support takes place outside of session time and is billed separately at R150 per session - this is not eligible to be claimed by medical aid. For clients paying privately, post-session treatment support is included in the session fee. I will provide you with an Invoice that you submit to your medical aid if your medical aid isn't on our list.

Annual fee increases will take place on the first of January each year. You will be notified.

CASH FEES

Individual therapy (R 1 350)
Couple's therapy (R 1 500)

EFT PAYMENT
Banking details:

Bank: FNB/RMB
Account Holder: Mr Sr Griffin T/A The Private Practice
Account Type: Gold Business Account
Account Number: 63167214972
Branch Code: 250655

Kindly send proof of payment to: **info@ThePrivatePracticeSA.co.za**

I understand the session fees and the optional post-session treatment support described above.

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4. MEDICAL AID

For us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a medical aid, it will usually provide some coverage for mental health treatment. If you are unsure, kindly contact your medical aid and ascertain whether they will pay for your therapy sessions.

You should also be aware that most medical aid companies require you to authorize me to provide them with a diagnosis. Though all medical aid companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. By signing this Agreement, you agree that I can provide information to your medical aid. You will also sign a waiver of confidentiality for any documentation that I complete for the medical aid. You have the right to pay for my services yourself to avoid the problems described above.

5. CONTACTING ME

My cellular phone is on silent when I am consulting with clients. The **quickest way to get hold of me is to send a WhatsApp or email me at Stephen@ThePrivatePracticeSA.co.za**

Please include your name and surname in the message. Kindly do not leave voice messages or voice notes. I read my emails and respond to WhatsApp messages at the end of the day and will try within reason to get back to you that day. Written follow-ups, task summaries, or structured reflections outside of session time form part of post-session treatment support where applicable.

6. CONSULTATION TIMES & DAYS, HOLIDAY/PUBLIC HOLIDAYS

- My practice is open from Monday to Friday between 09:00 and 17:00.
- Session: 50 minutes.
- I am not available on Sundays and Public Holidays.
- I will inform all clients timeously on taking leave. Please note that I am not available when I am on leave. Kindly respect my boundaries and do not send emails/voice messages/WhatsApp messages.
- In emergencies you will have the necessary contact details.
- My vacation response will be turned on when I am on leave. I will respond to all correspondence when I return to work.

7. APPOINTMENTS AND CANCELLATION OF APPOINTMENTS

Appointments will be once per week or every second week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. You are responsible for arriving on time; if you are late, your appointment will still end on the scheduled time.

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If you need to cancel or reschedule a session, I ask that you provide me with (at least) 24-hour notice. I require this time to contact clients on my waiting list. If you miss a session without cancelling, or cancel with less than 24-hour notice, my policy is that you will be responsible for payment. You will not be able to claim this session from medical aid. If it is possible, I will try to find another time to reschedule the appointment.

8. HOW DO I WORK?

Therapy is offered to adults and late adolescents in a confidential, calm, and non-judgemental space, whether in-person, online, or through a flexible hybrid format.

I use a multi-modal approach, which is grounded in practical support and psychological insight, with a focus on sustainable change. Drawing primarily from Cognitive Behavioural Therapy (CBT), Narrative Therapy, ACT, Solution-Focused Therapy, trauma-informed care, and mindfulness-based techniques, sessions are structured yet responsive, always tailored to the individual and their context. I pay careful attention not only to symptoms, but also to the systems, environments, and stories that shape them.

9. LIMITS OF CONFIDENTIALITY

I have been advised by Mr Stephen Griffin that all communications with me and all records relating to the provision of psychological services to me are confidential and may not be disclosed *without my written consent.*

I have also been advised by Mr Stephen Griffin that the law places certain limits on the confidential nature of the psychological service provided to me.

1. If I present an imminent danger to myself or others the law requires that steps be taken to prevent such harm.
2. If a child needs protection a report must be filed with the appropriate agency or authority.
3. If a vulnerable adult is abused or neglected a report may be filed with the appropriate government agency.
4. If a court orders the disclosure of records.

10. DISCLOSURE TO OTHER HEALTHCARE PROFESSIONALS

As part of providing responsible and coordinated psychological care, it may at times be clinically helpful for me to communicate with other healthcare professionals involved in your care (for example, a referring doctor, general practitioner, psychiatrist, or other treating practitioner).

Such communication is limited to information relevant to your psychological care and is intended to support collaborative, multidisciplinary treatment where appropriate.

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You may choose whether or not to provide consent for this type of communication. Consent is voluntary and may be withdrawn at any time without affecting your access to therapy or the nature of services provided.

If you wish to provide consent, please indicate the details below. If this section is left blank, no communication with other healthcare professionals will take place.

Healthcare professional (optional):
Name: _____
Role / Practice: _____
Contact details: _____

☐ I consent to communication as described above
☐ I do not consent to communication with other healthcare professionals at this stage

Any disclosure of information beyond the scope described above will require a separate, written, signed, and dated voluntary disclosure form, which will be discussed with you at the time if needed.

11. THERAPY: RISKS AND BENEFITS

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities which you need to understand. There are also legal limitations to those rights that you should be aware of.

Therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness, because the process of therapy often requires discussing the unpleasant aspects of your life.

However, therapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are no guarantees with regards to the outcome of psychotherapy. Therapy requires a continually active effort on your part. To be most successful, you will have to work on things we discuss - outside of sessions.

The first few sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise.

12. KINDLY RESPECT MY BOUNDARIES

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The National Health Act 61 of 2003 defines violence at work as "any incident in which a Healthcare Worker is abused, threatened or assaulted in circumstances relating to their work." This covers the serious or persistent use of verbal abuse, and/or inappropriate behaviour - which may cause, stress or anxiety, thereby damaging a Health Care Worker. It also covers staff who are assaulted or abused outside their place of work - for example, while going home, while working in the community or while traveling, if the incident relates to their work. The definition of physical assault used in the 2003 directions was "the intentional application of force against the person of another without lawful justification, resulting in physical injury or personal discomfort." In this instance the health care worker may terminate the therapeutic relationship.

13. NON-PAYMENT OF FEES

If you are unable to pay for a session, due to unforeseen financial constraints, please discuss this with me beforehand to arrange a payment option. Please note that it is my right to employ a Debt Collector if you do not pay for the professional services provided. A debt collector will be employed after 60 days of non-payment with no prior arrangement directly with myself or The Private Practice as an entity.

14. OTHER SERVICES

It is my practice to charge for other professional services that you may require, such as report writing, reading of emails, telephone conversations, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me.

If you anticipate becoming involved in a court case, I recommend that we discuss this fully. I do not do any forensic or legal work, this is not my area of expertise, and I would never feel comfortable in this situation. If your case requires my participation, understand that my participation is under duress, and you will be expected to pay for the professional time required even if another party compels me to testify.

15. ADOLESCENTS AND MINOR CHILDREN

The adolescent informed consent is a separate document that both parents need to complete.

I require parents/guardians of adolescents (under the age of 18 years) to sign the consent form.

While confidentiality in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 15 unless she/he agrees that I can share whatever information I consider necessary with the parents (Best interest of the child).

For children 15 and older, I request an agreement between myself, the client and the parents allowing me to share general information about treatment progress and attendance. All other communication will require the child's agreement, unless I feel there is a safety concern, in which case I will make every effort to notify the child of my intention to disclose information ahead of time.

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16. EMERGENCIES

If you feel you cannot wait for a return call/next appointment or if you feel unable to keep yourself safe, please go to your nearest local Hospital Emergency room/Out-patient section/Psychiatric Hospital.

We will discuss an emergency plan during our first session.

17. ELECTRONIC COMMUNICATION

Please note that I do not "befriend" anyone who is or has been a client of mine.

My email policy is this: You email me only for making/cancelling/changing therapy appointments.

If you send me emails/text messages to update me on your status, I will acknowledge where I am able to with limited time. Please do not feel disregarded if I am unable to reply, this generally means there are more pressing messages to attend. We can always discuss these aspects during your session. Post-session treatment support does not replace therapy sessions and is limited in scope.

If you want to show me something on Facebook or your blog or any other social media, or documents, letters etc, you can show me during our therapy session from your account.

18. OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk to me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect.

If at any time during our sessions, it is my professional opinion that I am not able to assist you (e.g., Outside my Scope of Practice), I will refer you to the appropriate professionals that will be able to assist you. We will discuss this during our sessions until you are comfortable with the referral options.

You may also request that I refer you to another therapist and you are free to end your therapy at any time.

You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, colour, gender, sexual orientation, age, or religion.

19. TELEPSYCHOLOGY

Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, emails, telephone conversations and/or education using interactive audio,

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video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually. Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person.

However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

20. CLIENT'S RIGHTS, RISKS, AND RESPONSIBILITIES

I understand that I have the following rights with respect to teletherapy:

1. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The HPCSA regulations that protect the confidentiality of information also apply to teletherapy. As such, I understand that the information disclosed by me during my therapy or consultation is confidential.
3. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form, I received at the start of my treatment with Mr Stephen Griffin.
4. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my psychologist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. There is also a risk that services could be disrupted or distorted by unforeseen technical problems.
5. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services.
6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
7. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency, I understand that I can proceed to the nearest hospital emergency room for help. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in future, my psychologist will recommend more appropriate services.
8. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment, and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychological treatment provider to do the same on their end.
9. I have read, understand, and agree to the information provided above regarding telehealth.

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PROTECTION OF PERSONAL INFORMATION ACT DOCUMENT

INTRODUCTION

- I have implemented several procedures to protect all personal information of clients and patients according to the Protection of Personal Information Act (POPIA) 4 of 2013, and the HPCSA, Form 223 regulations.
- The following POPIA clauses apply in addition to the Informed Consent form (Welcome to my Practice and Informed Consent form for Teletherapy) to be signed prior to our first consultation.

1. The undersigned agrees to the following additional terms and conditions:

a) **By providing the personal information** on the Informed Consent form, you consent to this information being kept and processed for the purposes of providing treatment and to contact you when necessary.
b) **By providing the information of an Emergency Contact**, you confirm that you have obtained consent from the person listed to provide their contact details as the person who will be contacted in the case of an emergency.
c) **By providing the information of your Medical Aid**, you confirm that you have obtained consent from the person listed to provide their contact details as the person who will be responsible for payment of the account.
d) I have **electronic safeguards** to protect against hacking and breaching of personal information. I have threat detection hardware on all devices containing personal information and review security safeguards on an ongoing basis to ensure that your information is kept safe and confidential. All computers and phones are password protected.
e) The cellular phone and computer belonging to my practice (**Mr Stephen Griffin**) is confidential and **messages/emails** will be read only by myself. However, there is always a risk of personal information breach that may be unavoidable when using electronic devices, particularly social media platforms such as WhatsApp.
f) Where specific requests are received to disclose information contained in your records (e.g., medical aid audits, other health care professionals), you have to complete a separate **Waiver of Confidentiality form** that will be provided to you.
g) **Hardcopy files** are stored away in a locked cupboard at all times. Information regarding the therapy process will be recorded in your file in order to provide psychotherapy services. This information will only be used for the purposes for which it was collected (providing psychotherapeutic and assessment services).

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Client/patient records are kept for a period of 6 years from the date of the last consultation or as regulated by professional standards set out by the HPCSA and will be safely disposed of/destroyed thereafter.

a) In the case of a **breach of personal information**, I will notify the individual whose information has been breached.
b) The undersigned acknowledges that using their name as a payment reference will reflect on my **bank statements and payment notification** emails/SMSs.
c) The undersigned acknowledges that they are responsible for providing me with a written request for an **update of personal information**, or correction, or deletion of their personal information.
d) Despite all these measures, the undersigned acknowledges that there remains a **risk of breach** of their personal information and does not hold me liable in case of such a breach.

There is always a risk of personal information breach that may be unavoidable when using electronic devices, particularly social media platforms such as WhatsApp.

Your signature below indicates that you have read this Agreement and agree to the terms.

Signature: _____

Date: _____

Stephen Griffin
Counselling Psychologist
The Private Practice
BA Psych - Cum Laude (UNISA); BA Psych Honours - Cum Laude & MA Couns. Psych (Wits)
PS 0164348 PR No. 1266624