

CLIENT DETAILS

Surname: _____ First Name: _____ Age: _____
Identity number: _____ Marital Status: _____ Spouse: _____
Children: _____ Ages: _____ Religion: _____
Phone number: _____ e-mail address: _____
Physical address: _____
Medical aid: _____ Plan type & Member number: _____
Person to contact in case of emergency: _____
Doctor/GP name and contact number: _____

IMPORTANT NOTICE:

By signing this document I confirm that I understand the below Privacy policy. I also confirm that I consent to being counselled by Lynn. I also understand that all sessions will be charged for in full if not cancelled 24 hours prior to the session.

POPI Act:

I am aware of the following regarding the practice’s POPI Act policy: We collect and store the information about you in order for us to adhere to administrative requirements of the practice and HPCSA regulation. We collect and store information about you in order for us to continually assess, treat and manage your best interest. We will use your personal information only for the purposes for which it was collected and agreed with you. We may disclose your personal information to our service providers who are involved in the delivery of services to you (i.e for billing purposes). We have agreements in place to ensure that they comply with the privacy requirements as required by the Protection of Personal Information Act. We will, on an on-going basis, continue to review our security controls and related processes to ensure that your personal information remains secure. You have the right to request a copy of the personal information we hold about you. Please note that any such access request may be subject to a payment of a legally allowable fee. You have the right to withdraw your consent to hold your information and to terminate our therapeutic relationship. We request that you do this in writing. As a practice, we do not sell any of your information to third parties. By signing this document, you confirm that you accept and understand the conditions of this agreement.

Signature(s) _____
Client and Person responsible for payment

Signed at _____ Date: _____

Lynn Clarkson Registered Counsellor
(BA Hons Psych)
HPCSA PR. NO. PRC 0005495
PR. NO. 081 000 0296120

0828762360

info@lynnclarkson.co.za www.lynnclarkson.co.za

