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(Reg No: 2015/308832/07)

DBT Skills Trainer
Individual DBT for adolescents
Individual DBT for BPD's
Adolescent and family counselling
Step-upp skills group for Adolescents and Tweens
Parent Support group

CHILD/ADOLESCENT CLIENT INFORMATION FORM

Surname: .... First name: ....

Identity Number: ....

Address: ....

City: .... Postal code: ....

Home phone: .... Cell Phone: ....

Email address: ....

School & Grade: ....

PARENT/GUARDIAN DETAILS

Surname: .... First name(s): ....

Relationship to client: ....

Identity Number: ....

Occupation & name of employer: ....

Work Address: ....

City: .... Postal code: ....

Home phone: ....Cell Phone: .... Work phone: ....

Email address: ....

Referred by: .... Tel number: ....

PERSON TO ALERT IN CASE OF EMERGENCY: (if different to above)

Name .... Contact number: ....

CONSENT FOR TREATMENT OF MINORS

Client name: ....

Date of birth: ....

Counsellor(s): Jonathan Mitchell

This document certifies that I give my permission to Glenbrook Practice and the counselor/s listed above for treatment of my child. This contract neither replaces nor alters the key-working role of others. DBT skills training neither replaces nor alters the key-working role of other professionals,Psychiatrist and Psychologist,currently seeing your child. DBT skills makes a distinction between the roles of other providers as it is skills based and not therapy. DBT® is a registered trademark of Marsha M. Linehan. ©STEP-UPP® is a registered trademark of Glenbrook Practice. ©The STEP-UPP® programme that has been adapted and written for the South African context is the property of Glenbrook Practice. Copyright 2020 Glenbrook Practice.

While the practitioners agree to take measures to ensure the safety and containment of the patient, they will not be held liable for any self-inflicted injury or relapse/suicide by client or otherwise, either during the course of the sessions or outside of those terms.

The practitioners will maintain confidentiality at all times. It is understood that they have permission to liaise with any relevant professionals such as psychologist, psychiatrist, school counselors and so forth regarding the client's treatment history and process.

Current Psychiatrist:..

PH..Email..

Current Psychologist:...

PH..Email..

Signature of Parents(s)/Guardian..

Date: ....

Printed names of Parents(s)/Guardian: ....

Witness:...

The agreed contracted fee is R620.00 per session and R800.00 for family sessions. There is also a one-off cost of R400.00 (this covers stationary, file and notes if required) Fees cannot be claimed from medical aid, as there is no claim number accredited.

1. The client agrees to take full responsibility for the settling of an account directly after each session. The practice operate on a cash-only basis. Any other payment is by prior arrangement only. Failure to cancel a session without 24 hours notice will result in the full charge being levied for that session.

2. While the practitioner agrees to take measures to ensure the safety and containment of the client, he will not be held liable for any self-inflicted injury and/or relapse/Suicide by the client or otherwise, either during the course of the session or outside of those times.

3. The practitioner will maintain confidentiality at all times. It is understood that he has permission to liaise with any relevant professionals such as psychologists, psychiatrists and so forth regarding the clients history and process.

4. There are some limits and exceptions to patient confidentiality:

CHILD OR ELDER ABUSE

Generally, Providers are required by law to report any known or suspected cases of child or elder abuse to the Children's Services Division or to any local law enforcement agency.

HARM TO SELF OR OTHERS

If a Provider learns that someone is about to kill or do harm to someone else she/he will do her/his best to warn the intended victim. If a Provider learns that a client intends to harm his/her self. The Provider will breach confidentiality to the extent necessary for his/her protection.

You acknowledge that you have read the above information, clarified any uncertainties and that you consider yourself bound to the contents therein.

Parents(s)/Guardian
Signature(s)..

Practitioner: J Mitchell ....

Signed at ....

Date:...