



clinic of collaborative interventions
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Consent Form for Clinical Psychologist

Nature of Service

The reasons why people enlist the service of a Clinical Psychologist vary considerably. Some people require assistance to help them through an immediate crisis whereas others come with quite long standing difficulties. Psychologists are different from Psychiatrists in that they are not medical practitioners and do not prescribe medication. Psychology is the study of human behaviour whereas Psychiatry is the study of mental illness. A Clinical Psychologist's qualifications include a 4-year undergraduate degree in Psychology and a 2-year postgraduate Masters degree in Psychology then 2-years additional weekly Clinical supervision. A PhD is a 4-year postgraduate degree. To maintain a high level of professional standards each of us are registered with the Australian Health Professional Regulation Agency, have completed further training with a diverse range of therapies and participate in regular supervision.

Your Consultation

The first consultation usually involves obtaining a description of what is troubling you. You may be asked to complete some questionnaires or psychological tests to help me get a clear picture of what aspects of your behaviour, thinking, or emotions create difficulties. I will then discuss how I see your problem and plans to address it. You are also likely to be given an estimate of how long this should take. Your sessions will focus on your current problems and any past events relevant to them. You will be encouraged to take a very active role in your own therapy programme, which includes reading and practical assignments between sessions.

Psychological Service

As part of providing a psychological service, I will need to collect and record personal information that is relevant to your current situation. This information will be a necessary part of the psychological assessment and treatment. At any stage, you are entitled to access a summary of your personal information kept on file, unless the relevant legislation provides otherwise. The psychologist may discuss with you appropriate forms of access.

Confidentiality

All personal information gathered during the provision of psychological services will remain confidential and secure except where:

1. It is subpoenaed by a court, or
2. Failure to disclose the information would place you or another person at serious and imminent risk; or
3. Your prior approval has been obtained to
 - a) provide a written report to another professional or agency. eg. a GP or a lawyer; or
 - b) discuss the material with another person, eg. a parent or employer;or if disclosure is otherwise required or authorised by law.

Fees

The recommended fee by the Australian Psychological Society for a session of approximately 50 minutes duration is \$280.00. Payments are required to be made on the day of the session and will be given a discounted fee, which is payable at the end of the session by bank card. Medicare rebates of approximately \$129.50 and applicable private health refunds are directly debited into clients account. There is no cash kept on premises. Unpaid accounts will be referred to our lawyer for debt collection and accordingly a legal and administration fee will be added to your account.

Cancellation Policy

If, for some reason you need to cancel or postpone the appointment, please give me at least 24 hours notice, otherwise you will be charged the full cost for the session. Sessions cancelled with 48-24 hours notice will incur 50% the session cost. The cancellation policy is in accordance with Australian Psychological Society's recommendations and reflects the time set aside for you and allows time to be offered to another patient who may be on a cancellation waiting list (Medicare and private health fund rebates do not apply to cancelled or missed appointments).

Charter for Clients of Psychologists

The attached Charter explains your rights as a client of a psychologist.

Policy for Management of Personal Information

The attached document describes the policy of Clinical Psychologists at Clinic of Collaborative Interventions, for the management of client information.

I, (print name), have read and understood the above Consent Form. I agree to these conditions for the psychological service provided by Clinical Psychologists at Clinic of Collaborative Interventions.

Signature Date

Please Note:

If, after reading this page you are at all unsure of what is written, please discuss it with the psychologist.

Date: _____

Client Background Questionnaire
(All Information is Strictly Private and Confidential)

The purpose of this short questionnaire is to obtain some basic background information about you for normal clinical management. Brief answers are sufficient. You are under no obligation or pressure to provide information you do not feel is necessary to provide.

Full Name: _____ **Preferred Name:** _____ **Date of Birth:** _____

Address: _____ **Suburb:** _____ **Postcode:** _____

Email: _____ **Telephone: (H)** _____ **(W)** _____

(Mobile) _____ ☐ may leave private message

In order to respect your privacy, in the event that we need to phone you please indicate if we may leave: ☐ a detailed message (at which of the above numbers? _____)

Birth Gender: _____ **: Gender Identity:** _____ **Preferred Gender Pronouns:** _____

Ethnicity/Cultural Identification: _____ **Country of Birth:** _____

Private Health Insurance _____ **Medicare Number:** _____ **Ref No.** _____

Referring GP/Psychiatrist/Psychologist: _____ **Date of referral:** _____

Address: _____ **Tel No:** _____ **Provider Number:** _____

Accommodation: What is your current accommodation/living situation (e.g., alone, sharing with friends, living with partner, living with family):

Occupation: Employed: ☐ (Full time/Part-time) Unemployed: ☐ Student: ☐ Retired/Home duties: ☐

Current/past occupations: _____

Relationship Status: (underline or circle as appropriate)

Single Married Separated Defacto Divorced Widowed Partner

Any children? (age and gender): _____

Name of person to contact in emergency: _____

Relationship to you: _____ **Tel No:** _____

Mental Health Problems:

Have you experienced mental health problems in the past? Yes/No; Hospital inpatient? Yes/No

Problem or diagnosis made	Year	Treatment/Therapist/Hospital

Family history of mental illness? (Yes/No): _____

Medication:

What prescribed medication do you take (including doses)? _____

What over-the-counter medication do you take frequently (i.e. painkillers, cough mixtures)?

Substance Use:

- Do you currently drink alcohol? Yes/No Average No. of standard drinks per week: _____
- Does the level of alcohol you consume cause you any problems in your daily life? Yes/No
- Do you currently use any illicit drugs? Yes/No

If yes, how often and type of drug: _____

Other Difficulties: please circle if any of the following have applied to you.

Learning/education problems	Depressed mood	Recent thoughts about not wanting to live
Eating problems	Hearing voices	Low social support/lack of friends
Large emotion swings	Excessive nervousness	Brooding over the past
Feeling detached or unreal	Social withdrawal	Intrusive memories of past experiences
Conflict in your relationships	Childhood problems	Repetitive/uncontrollable behaviours
Relationship problems	Self harm attempts	Excessive nervousness in social situations
Attention problems	Family problems	Avoid certain anxiety making situations
Low confidence	Difficulty asserting yourself	Elevated/Manic moods
Sleeping problems	Hard to relax	Legal problems

Current life stressors: _____

Medical Problems (include any diseases, disabilities, accidents or previous head injuries):

Past problems: _____

Ongoing problems: _____

You are invited to start thinking about what changes you would like to make in your thinking, behaviour, emotions and relationships. Your initial consultation will assess what life has been like for you and what your therapy goals are.

DASS₂₁

Name:

Date:

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3