Living Well
Psychology & Support

ABN 19862080399 P 07 5599 2201 F 07 5599 2202 W livingwellpsychology.com.au P PO Box 187, Tweed Heads NSW 2485

Tweed Heads
Suite 12, Level 1 Wharf Central, Corner Wharf & Frances Streets,
Tweed Heads NSW 2485
tweed@livingwellpsychology.com.au

Robina
Suite 2.2 Level 2 Space, 328 Scottsdale Drive,
Robina QLD 4226
robina@livingwellpsychology.com.au

NEW CLIENT REGISTRATION & CONSENT FORM

CLIENT DETAILS

Title: ____ Full Name: _____ Preferred Name: _____

DOB: ___ / ___ / ___ Gender: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Mobile: __ __ __ __ __ __ __ __ __ __ Other: __ __ __ __ __ __ __ __ __ __

Email: _____ @ _____

❑ I would like to receive **specific** information only ie: communication from my psychologist

❑ I am happy to receive **general** information also ie: practice news, mental health updates

❑ I would like access to my client portal to make appointments and payments via the website

GUARDIAN/ ALTERNATIVE CONTACT DETAILS

Full Name: _____ DOB: ___ / ___ / ____

Relationship to Client: ❑ Partner/ Spouse ❑ Parent /Guardian ❑ Other Family ❑ Friend ❑

Support Worker ❑ Case Manager ❑ Other: _____

Contact No: __ __ __ __ __ __ __ __ __ __ Email: _____@ _____

❑ Can be contacted if I cannot be reached to check that I am ok.
❑ Can make changes to my appointments and contact details on my behalf only.
❑ Can access my online client portal to make appointments/ payments on my behalf.
❑ Can claim Medicare rebates on my behalf. Medicare No: __ __ __ __ __ __ __ __ __ __ IRN: __

REFERRAL & BILLING INFORMATION

Referral Type:

❑ No Referral/ Self-referral

❑ Medicare - Mental Health Treatment Plan ❑ Medicare - Chronic Disease Management Plan

Medicare No: __ __ __ __ __ __ __ __ __ __ IRN: __

Referring Dr: _____ Date: ___ / ___ /____

Centrelink Concession Ref No: __ __ __ __ __ __ __ __ __ __

❑ DVA ❑ Gold Card ❑ White Card DVA File No: __ __ __ __ __ __ __ __ __ __

❑ NDIS Ref No: 4 __ __ __ __ __ __ __ __ Plan Manager: _____

❑ NSW WorkCover ❑ QLD WorkCover ❑ CTP

Insurer: _____ Claim No: _____

Living Well
Psychology & Support

ABN 19862080399 P 07 5599 2201 F 07 5599 2202 W livingwellpsychology.com.au P PO Box 187, Tweed Heads NSW 2485

Tweed Heads
Suite 12, Level 1 Wharf Central, Corner Wharf & Frances Streets,
Tweed Heads NSW 2485
tweed@livingwellpsychology.com.au

Robina
Suite 2.2 Level 2 Space, 328 Scottsdale Drive,
Robina QLD 4226
robina@livingwellpsychology.com.au

❑ Open Arms
❑ NSW Victims Services
❑ EAP
❑ Other: _____

Claim Contact: _____ Claim Ref: _____

How did you hear about us?
❑ Dr ❑ Word of mouth ❑ Website ❑ Other: _____

INFORMED CONSENT

a) I consent to my personal information being collected and held securely by Living Well Psychology & Counselling for the purposes of providing psychological services to me. I can find more information about the National Privacy Principles, accessing my information and Living Well's Privacy Policy from www.livingwellpsychology.com.au or my psychologist.
b) I understand that all information collected by Living Well Psychology is confidential and cannot be released to anyone without my consent. The exceptions to this are when my psychologist is mandated by law; subpoenaed by court; or if failure to disclose information would place me or another person at risk.
c) I give consent for Living Well Psychology & Counselling to seek and share information related to any referral or claim details I provide such as Medicare, WorkCover, North Coast Primary Health Network and any other service providers. I also give consent to my information being used for statistical and evaluation purposes to improve mental health services in Australia under these referral/claim programs. This will include details about me such as date of birth, gender, and types of services I use, but will not include identifiers such as my name, address, Medicare or Health Care/ Pension card number.
d) I am responsible for ensuring Living Well Psychology is provided with a current valid written referral and claiming details to bill directly to any third-party including Medicare or my insurer for services provided to me. I am responsible for ensuring this has been received prior to my appointment otherwise standard consultation fees are payable by me at my appointment.
e) I am responsible for any costs including consultation and cancellation fees as well as reports requested which are not covered by Medicare or other third party.
f) A Cancellation Fee of $50 will be payable by me if I fail to provide 24hrs notice of my inability to attend an appointment.
g) A Cancellation Fee between $75 and the full fee will be payable by me if I give less than 3hrs notice or I do not turn up to my appointment.

Signature: _____ (Client must sign if 14yrs+)

Print Name: _____ (Parent / Guardian if patient <14yrs)

Date: ___ / ___ / ___