SOCIAL WORKER
B.A. SOCIAL WORK (NWU)

ELRIKA hugo THERAPEUTIC SERVICES

EMAIL: elrika@linkedcare.co.za
WEBSITE: www.linkedcare.co.za
PRACTICE NR:0816167
TEL: 011 482 9007
SACSSP: 1032908

INFORMED CONSENT FOR THERAPEUTIC SERVICES

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully. When you sign this document, it will represent an agreement between us.

COUNSELLING SERVICES

I have a special interest in working with individuals/families, especially families who are supporting a loved one struggling with an eating disorder or who are facing interpersonal difficulties within their family system. My services include parental counselling (custody, and coparenting), marital/couples counselling, family therapy, trauma/bereavement counselling, mental health difficulties (depression, anxiety & eating disorders). Our first two sessions will involve an evaluation of your needs and a discussion about the presenting problem. My framework is based on a combination of CBT (Cognitive behavioral therapy) and DBT (Dialectical behavioral therapy) treatment modalities, which is skill-based interventions.

SESSIONS

If counselling is agreed upon, regular sessions of 50-60 minutes will be scheduled. In your treatment plan we will discuss how regular you need to be seen and what you would be able to commit to. Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. If it is possible, I will try to find another time to reschedule the appointment. Failure to cancel a scheduled session will result in a 50% fee for that scheduled session which will be payable before the next session is scheduled.

PROFESSIONAL FEES

My hourly rate is R800 with an annual increase as per medical aids. In addition to weekly or fortnightly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less thanone hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, consultation with other professionals you have authorized. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time if I am called to testify.

BILLING AND PAYMENTS/ MEDICAL AID BILLING

You will be expected to pay for each session at the time it is held unless we agree otherwise. PLEASE TAKE NOTE: I do not work with medical aids directly. You will be responsible for claiming from your medical aid. Payments can be cash on the day or via EFT where a proof of payment then needs to be pre-sent to me 0616652400, or elrikadelport12@gmail.com /elrika@linkedcare.co.za

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You will be issued with an electronic invoice. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment.

Banking details:

Bank: FNB (Cheque Account)

Account Holder: Elrika Hugo

Account nr: 62667621538

(Use your name as reference)

CONTACTING ME

I am not immediately available by telephone during the day, hence I would prefer for all communications to go through my email address (elrikadelport12@gmail.com/elrika@linkedcare.co.za). If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the mental health care professional [psychiatrist] on call. If I am unable to be available for our sessions due to crises, I will communicate this to you in advance. I consult from Mondays -Fridays at the Oxford day Clinic.

Practice address: Oxford Healthcare Centre, 75 Oxford Rd, Johannesburg 2196.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. These records will remain confidential.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a therapist is protected by law, and information about our work may only be released to others with your written permission. But there are a few exceptions:

- To protect you from potential harm: If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
- To protect others from potential harm: If it is believed that a client is threatening serious bodily harm to another, protective actions are legally required. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.
- Legal Proceedings: Should you be involved in any legal proceedings I may be subpoenaed to court to provide evidence, or my expert opinion should the court find it relevant to the case you are involved in.
- Child/ elderly/ disabled person's abuse: Should it come to my attention that a child, disabled or elderly person whom you are involved with is being abused physically, emotionally, verbally, or sexually I am obliged to report it to the authorities.

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I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client as protected by the POPIA Act. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

CLIENT INFORMATION REQUIRED
(PARENTS/CAREGIVER)

NAME & SURNAME:_____

ID NR:_____

MEDICAL AID:_____

MEDICAL AID MEMBERSHIP NR: _____

HOME ADDRESS:_____

CONTACT NR:_____

EMAIL :_____

DATE:_____

SIGNATURE:_____

CONSENT FOR YOUR CHILD/CHILDREN/LOVED TO BE SEEN BY THE SOCIAL WORKER

NAME & SURNAME OF THE CONCERNED CHILD:_____

DOB/ ID :_____

EMERGENCY CONTACT PERSON: _____

SIGNATURE OF PARENT/CAREGIVER: _____

DATE: _____