FILE NO.

072 944 5056
info@kaitlinyendall.com

HPCSA NO. PS 0145408
PR NO. 1027468

www.kaitlinyendall.com

Consent Form

Client Details

Title		Initials		Surname	
First name(s)					
ID number		Date of birth		Age	
Home language		Other languages			
Student number		Scholar at			
Occupation		Employer			
Email address					
Cell		Tel (H)		Tel (W)	
Postal address					
		Code			
Home address					
		Code			
Work address					
		Code			

Person Responsible for the Account

(Please complete this section if the person responsible for the account is not the above-mentioned client)

Title		Initials		Surname	
First name(s)					
ID number		Date of birth		Age	
Email address					
Cell		Tel (H)		Tel (W)	
Postal address					
		Code			
Occupation		Employer			
Work address					
		Code			

Account Details

Preferred method of communication (for accounts) - Mark (X)

☐ **Email address** ☐ **Post**

Payment method - Mark (X)

☐ **I am paying privately** ☐ **I am on a medical aid** (please complete the section below)

Medical Aid Details

Medical aid provider		**Medical aid plan/option**	
Name of main member		**Membership number**	
Relation to main member		**Dependent code**	

General Practitioner Details

Name of General Practitioner (GP)			
Address			
Tel (W)		**Cell**	
Email address			

Emergency Contact Information

Name of emergency contact person					
Cell		**Tel (H)**		**Tel (W)**	
Email address					

Referral Information

(If you were referred, please complete this section)

Referred by			
Tel (W)		**Cell**	
Email address			

Informed Consent

By signing this document, you acknowledge that you have read the accompanying *Client Information Document*, clarified any uncertainties that you may have, and now consider yourself bound to the contents thereof.

In addition, the client, or the guardian of the client, where applicable, gives his/her consent for me to collect, store, and process the client's personal information as indicated in the *Client Information Document*.

The client and/or the guardian of the client hereby give consent to participate in a therapy and/or assessment process.

Signature(s) ______________________ **&** ______________________

(Client) (Person responsible for payment)

Signed at ______________________ **Date** ______________________

For Clients Under the Age of 14

(In addition to the above, I require both parents / legal guardians to consent and sign the section below):

Full name (parent / legal guardian 1)

Contact number

Email address

Signature ______________________ **Date** ______________________

Full name (parent / legal guardian 2)

Contact number

Email address

Signature ______________________ **Date** ______________________