**Dr. Zoe L. Barnett – Clinical Psychologist**

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**Service Agreement Form**

**INFORMATION FOR CLIENTS**

**Client Name**:…………………………………………………………………………………………………………………………..

I/We have read and understood the APS charter for clients sent to me earlier from Dr. Zoe L. Barnett Clinical Psychologist.

I/We understand that my therapist will fully explain and obtain my informed consent before any treatment procedure is employed in my case.

I/We have discussed confidentiality of information and the legal and ethical implications to such confidentiality. Specifically, I/We understand that written notes will be taken and kept with my treating Psychologist. All files remain the property of my treating Psychologist.

I/We understand that only practice staff and my Psychologist have access to client files, and that all information is kept in strictest confidence except when a) a client directs communication with another interested party, b) the client is thought to be in danger to themselves or someone else or c) the court orders disclosure of information or d) the Australian Health Practitioner Regulation Agency (AHPRA) requests an audit of my file.

I/We understand that in the event my treating Psychologist ceases practice for health or personal reasons my file may be transferred to another Psychologist, at my Psychologist’s discretion, for the purposes of continuity of care.

I/We understand that I/We can withdraw from treatment at any time without prejudicing my future treatment here.

I/We have discussed the treatment with DR. ZOE L. BARNETT

and I/We have agreed upon a fee for this initial session of $250.00

and I/We Have agreed upon fee for subsequent session of $250.00

I/We understand that fees may change, and I/We will be advised of such changes.

I/We understand that fees for clinical reports and letters will be discussed and confirmed prior to work being completed.

I/We understand that the above fees are based on session duration of 45-50 minutes and that sessions of varying time will be charged accordingly.

I/We understand that phone calls/consultations of 15 minutes or longer will attract a fee. Phone calls are charged in blocks of 15 minutes. Costs for phone consults will be confirmed prior to the consultation.

**PLEASE NOTE** Dr. Zoe L. Barnett only provides Bulk Billing under pre-arranged special circumstances and payment is required at time of consultation. Non-payment incurs a non-refundable fee of $30 plus GST. Payments can be made using cash, cheque, Visa, Mastercard or Debit cards. Please note we do not accept AMEX credit cards.

I/We understand that text / SMS reminder messages are sent as a courtesy only and are not to be relied upon for attendance at appointments.

**I/We understand if 24 hour’s notice is not given (during standard business hours, 48 hours during weekend) to change or cancel an appointment, then a cancellation fee will be charged. The fee will be $150 including GST. Any requests for fee waived due to special circumstances should be provided in writing to my treating psychologist.**

I/We understand that information regarding private health cover needs to be discussed with your private health provider and that Dr. Zoe L. Barnett in no way guarantees any agreement held by clients with their private health insurers.

I/We understand that Dr. Zoe L. Barnett does not provide child supervision in the waiting rooms and that children play here at their own risk.

I/We understand that Dr. Zoe L. Barnett does not prepare medico legal reports for use in legal proceedings including tribunals.

I/We understand that where a GP / Psychiatrist / Pediatrician mental health treatment plan has been developed, that it is my responsibility to ensure that a) it is current b) I/We have regular reviews with the referring MHTP provider after 6 psychological sessions and c) I provide my psychologist with an updated review following each review.

I/We understand that I am eligible to claim under Medicare for a total of 20 psychological sessions and I will disclose any sessions I have utilized under my MHTP with another psychologist in the current calendar year, and that those sessions will reduce the number I am eligible with Dr. Zoe L. Barnett.

I/We consent to Dr. Zoe L. Barnett using the data from any outcome measures that I/We complete for research purposes and/or review of practice outcomes. I/We understand that any data used will be de-identified.

Dr. Zoe L. Barnett *reserves the right to change and/or update Clinic policy and procedures, for any reason, without prior notice.*

**Consent to receive psychological services by Dr. Zoe L. Barnett**

I have been provided with information about the service including the limitations to privacy and confidentiality and I have agreed that in circumstances where the psychologist is concerned about my welfare and is unable to contact me permission is provided for the psychologist to contact the following person:

Name:

Relationship:

Emergency Contact Number:

I, (print your name in Block Capitals)…………………………………………………….., have read and understood the information in this Consent Form and have discussed any outstanding questions with the practice/psychologist. I agree to the above conditions for psychological services to be provided by Dr Zoe L. Barnett.

Client signature ……………………………………………...............…………. Date ……./………/……..

***OR where signature is not possible psychologist’s confirmation of verbal consent:***

I have discussed the information in this consent form with the client and received verbal consent to proceed with clinical and/or telehealth services.

Psychologist signature ………………………………………………………………… Date ……./………/……..

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_