errolthepsychologist.com **Errol Akyalcin, Psychologist**

[**errolthepsychologist@gmail.com**](mailto:errolthepsychologist@gmail.com)MPsych(Couns), BA(Hons)

Reg. No: PSY0001123998

**Please carefully read this form. By signing this form you formally agree that you have understood its contents and that your Signature indicates that you give your Informed Consent to receive counselling & psychotherapy.**

**The following information describes the services provided to you by your psychologist.**

When you have carefully read, understood, signed and dated this Informed Consent Agreement.

You will receive a copy of this form for your records (original kept in your case file).

**Type of Services provided by your psychologist:**   
Psychological counselling and therapy, motivational and life coaching, and psychotherapy conducted in a traditional (face to face) room setting or phone consultations that are arranged by prior appointment.

The Psychologist, named above, may conduct verbal interviews, administer psychological questionnaires or tests, assess you via observations or gather historical information in order to determine your psychological state, levels of functioning, possible diagnosis and to assess your presenting issues.

Treatments utilizing a wide variety of psychological therapies/frameworks may be conducted during counselling sessions or outside of counselling in the form of set homework tasks, behaviour change routines, written tasks or records of progress toward treatment goals. All forms of psychological testing or therapy will be clearly explained and will only be conducted with your full Informed Consent as agreed by you signing this form.

**Counselling and psychotherapy sessions may also involve family members or significant others.**

Involvement of other significant persons (if required for therapeutic reasons) will only be entered into with your full consent and the informed consent of those parties involved. Documents/case file release also require consent.

You also understand that the Psychologist (stated above) follows the laws, professional regulations and ethics of the Australian Health Practitioner Regulation Agency (AHPRA). Professional Ethics regulations/practices cover all practitioner treatments, reports or tasks including face to face, phone or teleconferencing counselling formats.

**Confidentiality and its Limits:**

All discussions or notes taken during counselling and psychotherapy sessions are Confidential unless there is a significant risk of harm to your personal safety or to the personal safety of others (family, friends, associates, general public or to the wider society). Every effort is made to keep all information confidential in accordance with the legal requirements under Australian Privacy Principles set out in the Privacy Act 1988.

**Crisis or Emergencies out of hours:**   
If you are at immediate risk of suicide or other life-threatening crisis, by signing this Informed Consent Form you formally agree to immediately contact a crisis hotline, call **000** Emergency services or go to Hospital Emergency.

Personal Details   
  
 Name: …………………………………………………… Date of Birth: ………………………………………….

Address: ….……………………………………………………………………………………………………………….  
  
 Phone: ………………………………………………….. Mobile:…………………………………………………….

Email: ……………………………………………………………………………………………………………………..

Medicare Number: ……………....……………………………………………… Reference: ………………….  
  
 Expiry date: ……../……../………

Veteran’s Affairs Card Number: ……………………………………………. Reference: …………………

Expiry date: ……../……../………

Name of Emergency Contact: ……………………………………………………………………………………

Relationship: ………………………………………………………………..................................................

Emergency contact number: ……………………………………………………………………………………..

Treating GP’s name: ………………………………………………………………………………………………..

Treating GP’s address: ……………………………………………………………………………………………..

GP’s Medicare Provider Number: ……………………………………………………………………………..

Treating GP’s Contact Number: ………………………………………………………………………………..

**By completing and signing this form you are indicating that you have understood its contents and give your full Informed Consent to receiving psychological services, assessment, counselling and psychotherapy by your Psychologist. It is required by law that your Psychologist securely stores your Private Health Information. The contents of this Form will also be used on HealthKit ® Software.**

Signature of Client: ……………………………………………………………… Date: ..…../……../……..