Shona Scallan
PSYCHOLOGIST

Reg No. PSY0001579565

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CONSENT FORM

Psychological Service

As part of providing a psychological service to you, Shona Scallan will need to collect and record personal information from you that is relevant to your current situation. This information will be a necessary part of the psychological assessment and treatment that is conducted. You do not have to provide all of your personal information, however, failure to do so may result in the psychological service not being provided to you.

Purpose of collecting and holding information

The information is gathered as part of the assessment, diagnosis and treatment of the client's condition and is seen only by the psychologist. The information is retained in order to document what happens during sessions and enables the psychologist to provide a relevant and informed psychological service.

Access to client information

At any stage you as a client are entitled, unless relevant legislation provides otherwise, to access the information pertaining to you that is kept on file. The psychologist may discuss with you the appropriate forms of access.

Confidentiality

All personal information gathered by the psychologist during the provision of the psychological service will remain confidential and secure except where:

1. It is subpoenaed by a court, or
2. failure to disclose the information would place you or another person at serious and imminent risk, or
3. your prior approval has been obtained to:
    a. provide a written report to another professional or agency such as a GP or lawyer, or
    b. discuss the material with another person, eg. A parent or employer,or

if disclosure is otherwise required or requested by law.

Cancellation Policy
If, for whatever reason you need to to cancel, postpone or re schedule your appointment, please noitify us within at least 24 hours. Without 24 hours notice you will be charged the cost of the session.

Hours of operation

This practice is staffed on selected days only. If you require urgent attention after hours please contact your local emergency department or **Mental Health Emergency Response Line on 1300 555 788**.

I (Full name in block letters) _____

have read and understood the above client consent form. I agree to the conditions stated within and the peramaters of the psychological service provided by Shona Sarah Scallan.

Occasionally work such as written reports will be carried from other sites and some times client files may be transported for the purposes of writing and preparing reports. In this event, files are stored at that site in a secure filing cabinet. If you do not wish for this to occur please advise your psychologist.

If you have any questions about the content of this form, please discuss with your psychologist.

Client signature _____ Date: _____

Psychologist signature _____ Date: _____