0487 121 900
nicola@preiyapsychology.com.au

REGISTRATION and CONSENT FORM

Name: ____________________
Date of Birth: ____________________
I identify my Gender: ____________________

Residential Address: ____________________
Postal Address: ____________________
Post Code: ________

Phone: ____________________
Email: ____________________

Medicare Number: ____________ Ref: ________ Exp: ________
GP Name: ____________ Phone: ____________
GP Provider number: ____________________

Cultural Background: Aboriginal / Torres Strait Islander/ Other: ____________
Country of Birth: ____________________
Language/s spoken at home: ____________________

Emergency Contact: ____________________
Phone: ____________________

Reason for referral / what would you like to get out of therapy:

____
____
____
____

PRIVACY / CONFIDENTIALITY.

It is important you know that your privacy is protected at all times. *
Your client file includes personal information and session notes and it is secured. You can ask to see the information in your file. This information will remain confidential unless it is subpoenaed by a court; you give me permission to disclose the information; or my failure to disclose the information places you or another person at risk.

- I have read and understood this information.
- I also agree to pay for all sessions booked, if I do not cancel 24 hours ahead.

Signed: ____________________ Date: ____________

*Psychologists are bound by the legal requirements of the National Privacy Principles from the Privacy Amendment Act 2000 and follow strict guidelines for professional conduct that include confidentiality.