Informed Consent Information

**Psychological service**
As part of providing a psychological service (e.g. assessment, treatment planning, counselling/CBT, review and relapse prevention planning) to you, Rachael Willis/Pure Empowerment 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 give all personal information, but if you don’t this may mean the psychological service may not be able to be provided to you.

**Purpose of collecting and holding information/Privacy**
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. Administration staff at the practice will be able to view your personal demographic information and related correspondence to GP’s, but will not have access to your psychological file. Please refer to the Pure Empowerment Psychology “Privacy policy for management of personal information” should you require further information.

Here at Pure Empowerment, we also require your permission to use your personal mobile number to send you appointment reminders/cancellations/etc via our practice software system (Power Diary): SMS ❑ Email ❑ Phone ❑ (please tick all that apply). Please note, you can “opt out” at any time by writing “opt out” or “Stop” in reply to these messages and we will remove these reminder functions from Power Dairy.

**Access to client information**At any stage you as a client are entitled to access the information about you kept on file, unless the relevant legislation provides otherwise. The psychologist may discuss the appropriate forms or 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 risk, or
3. Your prior approval has been obtained to
4. Provide a written report to another professional or agency. E.g. a GP or a lawyer; or
5. Discuss the material with another person. E.g. a partner or employer; or
6. If disclosure is otherwise required or authorised by law.

**Fees**
See our Schedule of Fees page.
Phone calls required in-between scheduled consultations that are greater than 5 minutes long or emails greater than one page of writing, requiring time of the Clinician outside of the allocated therapy hour will incur a fee as per the APS schedule of fees. Emails will be printed off by the Clinician and bought into allocated session time to be discussed.

**Cancellation Policy**If for some reason you need to cancel or postpone the appointment, please give me at least 48 hours’ notice, otherwise you will be charged the cost of the consultation.

**Charted for Clients of Psychology**
The attached charted explains your rights as a client of a psychologist.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and understood the above consent form. I agree to these conditions for the psychological service provided by Clinical Psychologist, Rachael Willis.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Note: If after reading this page you are at all unsure of what is written, please discuss with the psychologist at the initial meeting/session.*

**Informed consent to release and obtain information**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby give permission to Rachael Willis, Clinical Psychologist from Pure Empowerment to obtain/release information from the following people.

GP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physiotherapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Podiatrist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dietician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Speech Pathologist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counsellor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Support Worker \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Carer/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand the obtaining/releasing of this information from the people nominated above; will assist in my care plan and treatment. I understand that this authority is valid for 12 months and may be changed or cancelled by me at any time. In order to cancel or change this authority, I must put this request in writing.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_