



CRISALIDA

CHILD, ADOLESCENT, ADULT & FAMILY THERAPY

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6A – GROUP REGISTRATION FORM

To complete this form digitally without Adobe Acrobat, download file, open and fill in, select PRINT and change the printer to SAVE AS PDF

CHILD'S DETAILS

Name: _____ DOB: _____ Gender: _____

Language/s Spoken at Home: _____

Home Address: _____

FAMILY/CONTACT INFORMATION

In cases with separated parents, we do require written consent from both parents/guardians in order to provide therapy. Refer to Informed Consent, Confidentiality & Release of Information policy on page 3.

Parent/Guardian 1: _____ Parent/Guardian 2: _____

Phone: _____ Phone: _____

Email: _____ Email: _____

Occupation: _____ Occupation: _____

Relationship to Child: _____ Relationship to Child: _____

Siblings (Names & Ages): _____

FUNDING:

- Private Health | Mental Health Care Plan | Enhanced Primary Care Plan
- NDIS (Self Managed) | NDIS (NDIA Managed*) | NDIS (Plan Managed*) | None

**Please note, we are restricted to only provide services under the 'Improved Daily Living' category and require a copy of the client's NDIS plan with this registration form.*

MEDICAL HISTORY: (eg. formal diagnoses, pregnancy & birth details, current medications, significant illnesses, hospitalisations, accidents etc)

Hearing Problems: No | Yes (please explain): _____

Vision Problems: No | Yes (please explain): _____

Allergies: (for clients with asthma or anaphylaxis - clients must bring their action plan and medication to each appointment)

EDUCATIONAL INFORMATION

School: _____ Grade: _____ Teacher: _____

General Academic Performance (describe strengths/weaknesses): _____

MAIN CONCERNS please check box and explain below:

- Learning difficulties
- Self-regulation
- Friendships
- Gross motor
- Play
- Dressing
- Fine Motor
- Behaviour
- Toileting
- Visual perceptual
- Speech/Language
- Other
- Cognitive Functioning
- Eating

Please explain concerns: if there is not enough space please feel free to attach supporting documents.

What are your goals for this child:

INFORMED CONSENT, CONFIDENTIALITY & RELEASE OF INFORMATION:

Please read the following statements regarding treatment, and sign to acknowledge you agree to these terms:

- As part of providing a service to you, we collect and record personal information from you that is relevant to your current situation. This information will be a necessary part of the assessment and treatment that is conducted.
- All personal information gathered by Crisalida during intake, assessment and/or therapy remains confidential and secure except in the following circumstances:
 - It is subpoenaed by a court
 - The therapist becomes aware of any risk to yourself or others
 - You agree to, and sign consent allowing material to be retrieved/forwarded to a third party, such as a GP or other clinician for treatment/management purposes
- Routine practice requires written and at times verbal communication with your referring doctor (if applicable) and supervising clinicians within Crisalida.
- If you are referred under a Mental Health Care Plan through Medicare written communication with your referring GP is mandatory after an initial six Medicare rebated sessions and any other subsequent sessions.
- Crisalida provides the groups as a package. If a session is missed, the cost will not be refunded as you are paying for the program to be planned, staffed and run in its entirety.
- It is not possible to schedule make up sessions for group programs in the instance of client non-attendance. In the instance of therapist illness or inability to attend group, a replacement therapist will be enlisted where possible.
- In cases where parents/guardians of a child are separated and there is a shared care arrangement or no formal custody arrangements, both carers must consent to the child undergoing treatment and/or therapy services at Crisalida by signing this form
- This form must be signed at intake in order for treatment or services to proceed. The patient cannot receive treatment or services unless this form has been completed

I have read the above informed consent, confidentiality, release of information, cancellation and group program policies. I am aware that the total program fee is payable regardless of attendance once the program is confirmed and commences. I am aware that cancellation fees are unable to be paid for by Medicare or FaHCSIA funding. I agree to the above conditions and to my self/child receiving clinical services at Crisalida

Child's Name: _____

Parents and/or Guardians:

Full Name
Address
Phone Number

Full Name
Address
Phone Number

Signature

Date

Signature

Date