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:
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	Full Name
_____	_____
Address	Address
_____	_____
Phone Number	Phone Number
_____	_____
Signature Date	Signature Date