CRISALIDA
CHILD, ADOLESCENT, ADULT & FAMILY THERAPY

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6C - FRIENDSHIP GROUP PROGRAM REVIEW OF PROGRESS AND NEW GOALS:

To complete this form digitally, download file, open and fill in, select PRINT and change the printer to SAVE AS PDF

Program Name:

CHILD'S DETAILS

NAME: DOB: GENDER:

HOME ADDRESS:

PRIMARY LANGUAGE SPOKEN AT HOME:

REFERRED BY:

FUNDING:

☐ Private Health | ☐ Mental Health Care Plan | ☐ NDIS (Self Managed)
☐ NDIS (NDIA Managed*) | ☐ NDIS (Plan Managed) | ☐ FAHCSIA | ☐ None

**Please note for NDIA Managed participants, 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.*

FAMILY/CONTACT INFORMATION

(in cases with separated parents, we do require consent from both parents/guardians in order to provide therapy)

Parent/Guardian 1:	Parent/Guardian 2:
Phone:	Phone:
Email:	Email:
Relationship to Child:	Relationship to Child:

EDUCATION:

School	Grade	Teacher/s

REVIEW:

PLEASE LIST ANY PAST PROGRAMS YOUR CHILD HAS ATTENDED AT CRISALIDA:

PROGRESS YOU HAVE NOTED:

CURRENT GOALS:

1.
2.
3.

CURRENT CONCERNS:

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

- Once the group program is confirmed, applicable fees are to be paid for the **entire group program**, regardless of client non-attended sessions. Groups require consistent clinical input for the entire program and need to be funded and staffed to ensure this occurs.

- 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 order that therapists' time is utilised effectively and that therapists cover their time and expenses, given the time that they spend in preparing for sessions, for a group program to be confirmed, complete program fees are necessary.

- Where a shared care arrangement is in place, or where custody arrangements are not established, both carers must consent to the child undergoing group treatment or therapy services at Crisalida by signing this form.

- This form must be signed before the first session in order for treatment or services to proceed. The client cannot receive treatment or services unless this form has been completed

- Privacy, confidentiality, and sharing of information arrangements can be discussed by carers with their Crisalida therapists

- Routine practice requires written and at times verbal communication with your referring doctor (if applicable).

I, _____, have read the above consent 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 agree to the above conditions and to my self/child receiving clinical services at Crisalida.

Name of Client: _____

Parents and/or Guardians:

_____

please print full name(s)

_____

sign date

Thank you for your time in completing this form. All information is confidential.
Please send to CRISALIDA admin@crisalida.com.au to register your interest.