CRISALIDA
CHILD, ADOLESCENT, ADULT & FAMILY THERAPY

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2A – Registration Form (Adolescent/Adult)

To complete this form online: save to your computer, open file and fill in, select PRINT and change the printer to SAVE AS PDF.

Patient Details

Name: DOB:

School/Occupation: Gender:

Home Address:

Phone: Mobile:

Email:

Emergency Contact or Guardian:

Relationship to patient:

Phone: Mobile:

History

Do you have a mental health diagnosis? ☐YES |☐NO

If yes, please explain:

Have you seen a mental health professional in the past? ☐YES |☐NO

If so, name of the previous practitioner: Phone:

Do you have any family history of mental illness/disability: ☐YES |☐NO

If yes, please explain:

Detailed Reason for Referral

Referrer Details

Name: Clinic:

Phone: Fax:

Therapy Type: ☐ Psychology | ☐ Mental Health Occupational Therapy | ☐ Occupational Therapy
☐ Group Therapy | ☐ Art Therapy | ☐ Unsure of which service best suits my situation

Funding: ☐ Private Health | ☐ Mental Health Care Plan | ☐ Enhanced Primary 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.*

Preferred Appointment Time: please tick (✓) all that apply

DAY	MON	TUES	WED	THURS	FRI	SAT
MORNING 8.30AM-12PM						
AFTERNOON 12-3PM						
AFTER SCHOOL 3-9PM						

Please note: afterschool and Saturday appointments are limited and may result in a longer wait period if this is your only availability

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 referring GP is mandatory after an initial six Medicare rebated sessions and any other subsequent sessions.
- Applicable fees are to be paid at each session unless otherwise negotiated with my treating therapist.
- Where a shared care arrangement is in place, or where custody arrangements are not established for minors, both carers must consent to the child undergoing treatment or therapy services at Crisalida by signing this form.
- This form must be signed before or at the first session in order for treatment or services to proceed. The patient cannot receive treatment or services unless this form has been completed
- So that therapists' time is utilised effectively, a cancellation fee to the value of 100% of the session fee applies if the client does not attend their appointment, or give more than 24 hours notice of non-attendance.

I acknowledge that I have read Crisalida's informed consent, confidentiality and release of information statement and give consent to the parties listed below to release and request information related to my history and treatment. I understand that this permission can be revoked at any time by myself in writing except for the information that has already been communicated.

Please list any GP, Specialist, Occupational, Physical or Speech Therapist, Neurologist, Psychologist, Psychiatrist, Teacher etc that you would like your Crisalida therapist to communicate with:

Name:
Address/Clinic:
Phone: Fax: Email:

Name:
Address/Clinic:
Phone: Fax: Email:

Name:
Address/Clinic:
Phone: Fax: Email:

Name:
Address/Clinic:
Phone: Fax: Email:

Please tick:

☐ I consent to my therapist communicating within the Crisalida Therapy team

I, _____, have read the above informed consent, confidentiality, release of information and cancellation policies. 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, Adolescent and Family Therapy.

_____
please print full name

_____
sign date