CONFIDENTIAL INFORMATION

Registration

DATE:_____ Melbourne Clinic ☐ Main Beach Clinic ☐

Your Details

Name _____ Male / Female

Date of Birth_____ Occupation _____

Partner _____ Number of Children _____

Address _____

Suburb_____State_____ Postcode_____

Telephone _____Mobile _____

Email _____

Any previous counselling? ☐ Yes ☐ No If yes, please detail:

_____

_____

_____

Medical Problems_____

Method of Payment

☐ Cash ☐ EFTPOS ☐ Work Cover ☐ DVA ☐ TAC

☐ Other ☐ EAP Company Name _____

I accept to be charged 50% of my consultation fee when a MINIMUM of 24 HOURS NOTICE is not given for cancelling or postponing an appointment

Client Signature_____DATE_____

Psychologist Signature_____DATE_____