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| --- | --- | --- | --- | --- | --- | --- |
| **TO BE COMPLETED BEFORE THERAPY CAN BEGIN.**  The following document is intended to form a professional agreement on behalf of the client(s) detailed below. Failure to adhere to the agreed contract by either party may lead to the termination of the treatment. | | | | | | |
| **Details of Client:** | | | | | | |
| Name: | | | | Tel: | | |
| Address: | | | | Mobile: | | |
|  | | | | Email: | | |
|  | Post code: | | | DOB: | | |
| **Details for client(s)** | | | |  | | |
| Name: | | | DOB: |  |  | |
| **Funding Agency Details - Privately Funded**  **Please Note: All private paying clients are required to pay for their sessions upfront, prior to each session. Bank Account details are provided upon referral and we accept card payment at head office.** | | | | | | |
| **Referral Details** | | | | | | |
| Contact name: | | | | | | |
| Address: | | | | | | |
|  | | Post code: | | | | |
| Tel No: | | | | | | |
| Email: | | | | | | |
| **Details of other professionals or carers involved:** | | | | | | |
| Name: | | | | Contact number: | | |
| Name: | | | | Contact number: | | |
| Name: | | | | Contact number: | | |
| Name: | | | | Contact number: | | |
| **Medical information** (continue over leaf if necessary) | | | | **Services requested** | | **Number of sessions** |
|  | | | | Psychological assessment | |  |
| Psychotherapeutic assessment | |  |
| Therapy | |  |
| Initial Consultation | |  |
| NMT Assessment | |  |
| Other | |  |
| **Scheduled Agreements:** | | | | | | |
| It has been agreed that JSA Psychotherapy Ltd will provide (name here) with the agreed scheduling of 1 Hour(s) a week, the length of X sessions, at the cost of £90.00 per hour with a total cost of £X  Meetings are charged at an additional £90.00 per hour.  Update reports and ending reports are charged at an additional £90.00 per hour.  A travel charge is incurred for any meetings and therapy commencing outside of the JSA offices, the cost of this at 0.45p per mile and £40.00 per hour travelled. | | | | | | |
| **Referral:** It may be possible that therapeutic work may have successfully highlighted the need for recommendation of referral to another counselling/psychotherapist practitioner for some form of specialist therapy/psychology, beyond the scope of the therapist’s professional training and experience.   Alternatively, it may (for example) include GP referral for possible medication/or GP referral to another NHS/Professional consultant. | | | | | | |
| **Terms and conditions:** | | | | | | |
| * All therapists hold relevant professional qualifications and are registered with a health professions association * All therapist a hold current DBS * Any additional work deemed necessary will be subject to new agreement * All parties will be advised of any changes to planned programme * All therapists are fully covered by public liability and professional indemnity insurance. * All private paying clients are required to pay for each therapy session upfront, prior to the session. | | | | | | |
| **Reasons for referral** (please continue on another sheet) | | | | | | |
|  | | | | | | |
| **Desired out-comes** | | | | | | |
|  | | | | | | |
| **Consent** | | | | | | |
| I give consent for …………………………………. to attend the programme confirmed above.  **Client’s Signature: Date:** | | | | | | |
| **Cancelations/no shows:** | | | | | | |
| Sessions cancelled without 24-hour notice will be charged at the full rate, unless both agree that this occurred due to circumstances beyond the client’s control. | | | | | | |
| **Client’s Signature: Signed: Date:**    (The person signing this form must be an agency representative) | | | | | | |