|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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. | | | | |
| **Client Details:** | | | | |
| Name: | | | Tel: | |
| Address: | | | Mobile: | |
|  | | | Email: | |
|  | Post code: | | DOB: | |
| **Prior Authority agreed: Yes No N/A** | | | | |
| **Authority Details** | | | | |
| Referral Agency: | | | | |
| Contact name: | | | | |
| Address: | | | | |
|  | | Post code: | | |
| Tel No: | | | | |
| Email: | | | | |
| **Finance Department Details (this section must be fully completed prior to the work starting)** | | | | |
| Finance Department: | | | | |
| Contact name: | | | | |
| Invoicing Contact Address: | | | | |
|  | | Post code: | | |
| Tel No: | | | | |
| Email: | | | | |
| **We cannot begin this work without a PO number, if there isn’t a PO number required, please state below.** | | | | |
| **PO Number:** | | | | |
| **Details of professionals involved** (Health, Legal, etc.) | | | | |
| Name: | | | Contact No: | |
| Name: | | | Contact No: | |
| Name: | | | Contact No: | |
| Name: | | | Contact No: | |
| **Medical information** (continue over leaf if necessary) | | | **Services requested** | **Number of sessions** |
|  | | | Psychological assessment |  |
|  | | | Psychotherapeutic assessment |  |
|  | | | Therapy |  |
|  | | | Initial Consultation |  |
|  | | | NMT Assessment |  |
|  | | | Other |  |
| **Identified Risk:** | | | | |
| **Scheduled Agreements:** | | | | |
| It has been agreed that JSA Psychotherapy Ltd will provide (name here) with the agreed schedule of 50 minutes per week for the duration of X sessions, at the cost of £115.00 per session with a total cost of X.  Meetings are changed at an additional £105.00 per hour.  Update reports or end of therapy forms are charged at £105.00 per report.  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 | | | | |
| **Reasons for referral** (please continue on another sheet) | | | | |
|  | | | | |
| **Desired out-comes:** | | | | |
|  | | | | |
| **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. | | | | |
| **Social Worker: Signed: Date:**  **Social worker Manager: Signed: Date:**    (The person signing this form must be an agency representative) | | | | |
| **Signed by representative from the Finance Department: Date:**    (The person signing this form must be an agency representative) | | | | |