changes
psychotherapy

TERMS OF SERVICE AGREEMENT FORM

1. Fee Schedule

SESSION TYPE	FEE
Individual Session 50 min	$155.00
Individual Session 80 min	$225.00
Couple Session 50 min	$235.00
Couple Session 80 min	$330.00
EMDR Phase 1-7 50 min	$155.00
EMDR Phase 1-7 80 min	$225.00
Supervision session 50 min	$185.00

**A maximum of four family members per family session applies, however if you require more, additional fees apply
**Addiction intervention services are available upon request
**Please enquire directly about Gottman couples therapy session protocols

2. Clinical Registration

Marryam is a full clinical member of the Psychotherapist and Counsellors Federation of Australia (PACFA 22801), a Level 3, Certified Gottman Therapist and a Full Member of the EMRDA Association of Australia. You can search here https://www.pacfa.org.au/find-a-therapist/ here https://relationshipinstitute.com.au/therapists/ and here https://emdraa.org/find-a-therapist/

3. Private Health Insurance Rebates

Changes Psychotherapy can provide health insurance rebates through two providers. Please contact your health insurance provider directly to find out if you're eligible and quote provider number. Please note, below you can see ***my provider*** numbers, ***not item numbers.*** Please check with your health insurance directly for more information:

a. Medibank Private *Provider* Number A097391Y
b. Bupa *Provider* Number J114731

4. Payment Terms and Details

a. We accept cash, credit card and electronic funds transfer (EFT) only
b. Cash or card payment is only available face to face and is due at the beginning of your session
c. EFT payment and email proof of payment is due 24 hours before your session and confirms your appointment
d. Please email EFT proof of payment to info@changes-psychotherapy.com a *minimum* 24 hours before your session
e. Clients who pay and/or provide proof of payment less than 24 hours prior to their session, will forfeit their spot and the appointment may be cancelled without notice. ***Only*** an Emergency Department hospital admission with a doctor's certificate, will not incur any No Show or Missed Appointment fees.
f. We do not accept third party payments unless it is through an authorised compensation claim provider
   Please make payment to:
   Bank of Queensland
   Changes Psychotherapy
   BSB: 122-712
   ACC: 230-530-22

5. No Show and Late Cancellation Penalties
   a. Late cancellation inside 24 hours before your session will incur 100% cancellation fee
   b. Cancellations are required in writing or through your cancellation link provided via email
   c. No Shows and Missed Appointments attract a 100% "no show" fee
   d. Arriving late does not extend your session time

6. Privacy and Confidentiality

All session notes are electronic, and password protected. The therapist may take notes during your session, but these physical notes are destroyed once they are recorded in your electronic file. Once therapy has ended, Changes Psychotherapy keeps your case file for a period of ten years. After this time, your record is destroyed or anonymised.
Your privacy and confidentially is of the highest importance and protected by law, except when:

   a. A child is at risk of harm;
   b. You disclose you are suicidal or homicidal;
   c. You disclose you intend to commit a crime that carries a jail term of five years or more;
   d. I receive a court subpoena;

7. Therapy Cessation

Therapy comes to an end when symptoms are resolved and/or you decide to stop for other reasons. One minimum session is required to end safely. Changes Psychotherapy reserves the right to cease service at the discretion of the therapist.

8. What to expect

Initial sessions are an assessment period, mainly comprised of gathering detailed information to ascertain what has brought you to therapy. On completion of this initial phase, a therapeutic treatment plan will be discussed with you.

9. Client Information

Please provide the following details:

Full Name	
Date of Birth	
Postal Address	
Phone Number	
Email Address	
Occupation	
Next of Kin (NOK) Name	
NOK Relationship & Number	
Single or Coupled	
Medicare Number & position	
Private Health Insurance	

10. Agreement

I have read, understood and agree with all terms and conditions as set out above and I sign below as proof of this.

Client Full Name _____ DOB _____

Client Signature _____ Date _____