DR LAURA N. MILLER
MBBCH (Wits), Mmed (Psych), FC Psych (SA)
SPECIALIST PSYCHIATRIST

HPCSA: MP0679887
Practice No: 0760722
Psychiatric services – Client agreement
Drl.n.millerpsychiatry@gmail.com

Dear Client/s

How things work:

Welcome to my practice.
This document contains important information regarding my professional services and business policies and explains what your responsibilities are. Signature of this document represents an agreement between us.
Please read through it carefully and discuss anything which you do not understand.

Informed consent, assent and the nature of the therapeutic process:
The therapeutic process represents a relationship between service provider and client/s. As such you have certain rights and responsibilities which are important for you to be aware of. It is also important that you understand the legal limitations of these rights and responsibilities.
As a medical specialist the management process may include the prescription of certain medications, psychotherapy, and referral to/ joint work with a variety of other professionals.
As with any medical treatment there can be both benefits and risks to psychiatric interventions. Prescription medication may have side effects which will be discussed with you in greater detail during individual consultation depending on the medication which is being prescribed. Potential risks arising from therapy may include the experience of negative and uncomfortable emotions which produce some distress.
The success of therapy is influenced by many factors including the degree to which participants are prepared to take responsibility to bring about change. A successful outcome cannot be guaranteed.
If you are unhappy with the way in which our management plan is proceeding, please bring this to my attention so that we can address your concerns and respond accordingly. If at any point you should wish to seek an alternative opinion, you may request referral to another professional.
You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, colour, gender, sexual orientation, age, or religion.

Confidentiality and limits to confidentiality:

The information obtained about clients during a psychiatric interview is extremely personal and private information. As such please be sure to read and understand the following very carefully.
All records related to the provision of psychiatric services are treated as highly confidential. Unless exceptional situations (such as those outlined in 3 below) arise, I will not disclose any information without your consent.
In order to offer a professional service, academic material and cases are sometimes written up and discussed with suitable senior colleagues. Identifying details are avoided. The professionals concerned are all highly qualified and will treat all information as confidential.
In certain circumstances legal or professional rules may necessitate my disclosure of information. These include the following situations:
3.1 If the client presents a danger to him/ herself or to others, steps may need to be taken to prevent such harm from occurring.
3.2 If the abuse/ neglect/ endangerment of a child is suspected, I am legally required to make notification to the relevant authorities in order to ensure the protection of the child.
3.3 If abuse/ neglect of a vulnerable adult is reported to me a report shall be filed to relevant authorities.
3.4 Court orders may require me to disclose confidential information.

Repeat Prescriptions:

Legally I am required to see a patient in person for a follow up <u>at least</u> every 6 months in order to continue giving repeat prescriptions.
If a patient is stable on treatment it may be unnecessary to come for monthly follow ups. Certain prescription medications (eg schedule 6 medications such as Ritalin and Concerta), however, need to be rewritten on a monthly basis and cannot have repeats written on the script.

Cancellations and late arrivals:

Psychiatric services are time consuming and require a lot of additional input. As such these services often have to be booked months in advance. It would be a great pity to not arrive for such an appointment as it would mean that others who require appointments are not afforded the opportunity.
Appointments need to be cancelled at least 24 hours in advance

Please be on time for your appointments as I require the full amount of time allocated in order to offer you appropriate quality of service. If you should arrive late for your appointment, I may be unable to complete the full evaluation/ follow-up as I need to be on time for my next patient.

Emergencies:

Please email or call the practice during working hours should you have any non-urgent queries or concerns and I will get back to you as soon as possible. Please be aware that this is a part time practice.
Please be aware that I may not always be able to answer your call immediately. Should you have a medical emergency or feel that you are unable to keep yourself safe currently, please go to your nearest emergency department immediately.
If it is felt that admission may be warranted, you will be referred to an appropriate admitting practitioner who will be responsible for your care whilst in hospital. You will have to sign the appropriate consent/ confidentiality agreements with that practitioner for you in hospital management.

Medical aids:

Medical aids require an International Statistical Classification of Disease and Health Problems Code/s (ICD 10 Code). Please note that it is a requirement that this code be on the statements for your medical aid as well as on any prescriptions
Please note that certain future policies may require your medical aid to have access to the diagnosis of this treatment.
By signing this Agreement, you are agreeing that I provide such information to your medical aid.
You have the right to pay for my services yourself and not submit the claim to your medical aid in order to avoid the disclosure of diagnostic/ procedural codes as described above.
Please feel free to discuss any questions you have about the ICD code with me.

POPIA:

In line with the POPIA, Act 4 of 2013, we respect your right to your privacy regarding your personal information. It is our responsibility to inform you that we do use 3rd party software to do our billing. It is also necessary for us to contact your medical-aid from time to time to follow up on payments and benefits, and when being issued repeat scripts over S5 via email, we need to send them directly to your pharmacy. There may also be times when you are under several therapists that they interact to discuss your progress and the best way to move forward with your treatment. Furthermore, we may need to send out personal information to request and follow up on medical procedure, such as, but not limited to: blood test, scan x-ray's etc. In signing this agreement, you consent to us sharing your information with 3rd parties when necessary.

Consent:

Your signature below indicates that you have read this agreement and agree to the terms.
If attending an evaluation for a child patient less than 12 years of age, then both parents are required to sign before treatment can be commenced.
If the child is over 12 years of age and of sufficient maturity, then he/ she must sign in addition to the parents/ those responsible for the account.

I acknowledge and understand the benefits and risks associated with psychiatric evaluation and treatment as made known to me by Dr Laura Miller and as reflected in this form.

I hereby provide consent to participate in this process.

_____	_____	_____
Name and Surname of Patient	**Signature of Patient**	**Date**

In the case of a minor (Child under the age of 18 years)

_____	_____	_____
Name and Surname of Biological Mother	**Signature Biological Mother**	**Date**
_____	_____	_____
Name and Surname of Biological Father	**Signature Biological Father**	**Date**
_____	_____	_____
Name and Surname of Legal Guardian	**Signature Legal Guardian**	**Date**

In the case of the consent being signed by a legal guardian, by what virtue have you been granted guardianship & when:

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