Dr. Sam (Waisam) Hoong

Registration and Consent Form

First Name: _____ Last Name: _____

DOB: ____/_____/ _____ Address: _____

Mobile: _____ Email: _____

Medicare no. _____ Ref ____ Expiry Date _____

Emergency Contact: Name; _____ Relationship to you: _____

Access to your information. At any point you are entitled to access your information and the notes that kept of our sessions.

Confidentiality. All information provided will remain confidential except the following:

1. Disclosure is required by law
2. Failure to disclose would place you or another person at serious risk
3. With your health professional to facilitate treatment
4. Written consent has been obtained

Payment & Cancellation Policy

Missed sessions or cancellation made within 48 hours will incur a fee of $150

The standard fee for a 50-minute session is $210. Medicare and private health rebates are available. If you have a current Mental Health Care Plan, you will be eligible for a rebate of $126.50. Your out of pocket fee will be $83.50

Credit Card Authorization

I, _____, have read and understand this Payment and Cancellation Policy and authorize my credit card to be charged for any outstanding fees. I understand my credit card details will only be used for overdue fees, late cancellation, or with consent for the payment of regular sessions.

Card no: ____ ____ ___ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Card holder's Name: _____

Card Expiry Date: ____ /____ /_____ CVC: _____

Signature: _____ Date: _____ /_____ / _____

I have read and understand and agree to the conditions set out in this Consent form for the psychological services provided by Dr. Sam (Waisam) Hoong

Name: _____ Signature: _____ Date: ___ /___ /_____