APS charter for clients of psychologists

Before people can work as psychologists they must be registered with the Psychology Board of Australia (PBA). Your psychologist is a member of the Australian Psychological Society (APS), which is the largest professional association of psychologists in Australia, with a comprehensive Code of Ethics and complementary series of Ethical Guidelines.

As a client of an APS psychologist, you have a right to expect that:

- You will be treated with respect
- You will receive a clear explanation of the service you will receive
- Your consent for any service will be sought by the psychologist prior to the service commencing and as it progresses
- You will receive an explanation about the nature and limits of confidentiality surrounding the service
- You will be clear about the goals that you and the psychologist are working toward
- You will receive competent and professional service
- You will receive a clear statement about fees
- An estimate of the number of sessions required to achieve your goals will be discussed
- You will receive a service free from sexual harassment
- You will be shown respect for your cultural background and language tradition

Note:

If you have any concerns about the above matters, discuss them with your psychologist. If you have concerns about the conduct of your psychologist, you may call either the Psychology Board of Australia on 1300 419 495, or the Australian Psychological Society on (03) 8662 3300.

The Australian Psychological Society Limited
PO Box 38 Flinders Lane
Melbourne VIC 8009 Australia
Telephone (03) 8662 3300
Facsimile (03) 9663 6177
www.psychology.org.au

Parent Permission Form

Psychological Services

As part of providing a service to you and your child, personal information will be collected. This information will be used to guide the assessment and treatment of your child. You / your child do not have to give all the requested personal information, however withholding information may limit the psychological services that can be provided.

Confidentiality

Clients have the right to have their personal information protected. All clinical files are confidential, and remain the property of Valli Jones. All personal information will remain confidential and secure except where:

1. A legal request for access is made, such as a subpoena; or
2. Failure to disclose the information would place the client or another person at serious and imminent risk; or
3. Prior approval has been obtained to
   a) provide a written report to another professional or agency, or
   b) discuss the material with another person.

Access to Client Information

Young people over the age of 15 are entitled to access their personal information. Parents or legal guardians of children under the age of 15 are similarly entitled to access the child's personal information. Valli may discuss with you appropriate forms of access.

The attached APS Charter explains your rights as a client of a psychologist.

In referring my/our son/daughter _____

for psychological service, I/we acknowledge that:

1. Treatment may include administration of formal tests considered relevant to diagnosis.
2. Information will be exchanged between Valli Jones and the referring General Practitioner as required by Medicare; specifically, a Mental Health review report will be forward to the referring doctor at the completion of the 6th and 10th session.
3. Where consent is provided, Valli Jones may:
   - Communicate with persons who are or have been directly concerned with the care or education of the student (such as therapists, specialists, and teachers). This may involve communicating with them verbally and in writing, to seek information about

Initials……

the student's background, abilities and performance that may be relevant to the service being provided, and in relation to providing support, treatment, or assessment.

- Carry out observations of the child's behaviour and performance in the school setting, where appropriate and necessary.
- Use any relevant information available to assist in consulting with the educational personnel and other professionals involved with the child, with the intent of supporting and improving the overall functioning and wellbeing of the student.

Do you consent for your child to be involved in individual sessions with Valli Jones?

Yes	No
☐	☐

Do you consent for your child to be involved in group activities with other referred children when these are available? Please note that individual session discussion is independent of group work sessions, and confidentiality is not compromised.

Yes	No
☐	☐

With your consent, Valli Jones will work collaboratively with healthcare professionals and school staff in order to best support your child. Please indicate whether you give your permission for information about your child to be shared between Valli and the following:

	Yes	No
School Principal/Assistant Principal	☐	☐
Guidance Officer / Wellbeing Staff	☐	☐
Classroom Teacher	☐	☐
General Practitioner	☐	☐

Initials……

Please provide the details of any other health professionals your child is engaged with (i.e., paediatrician, naturopath, speech pathologist, occupational therapist)

Do you give permission for information to be shared between Valli Jones and the health professionals listed above?

Yes ☐ No ☐

Please sign below to indicate that you have read and understood the information contained in this parent permission form, and agree to these conditions for the services provided by Valli Jones.

Parent / Guardian 1

Name _____

Signature _____

Date _____

Parent / Guardian 2

Name _____

Signature _____

Date _____

Please sign and return, and keep a copy for your records.

Initials……

Confidential Client Information
Kindly complete this form and bring it with you to your child's first session.

Child's Name	
Child's Date of Birth	
Gender	
School	
Class & Teacher's Name	
Non-English speaking background	☐ Yes ☐ No
Aboriginal or Torres Strait Islander Background	☐ Yes ☐ No
Parent / Guardian 1	
Relationship to Child	
Phone number(s)	
Permission to leave a message	☐ Yes ☐ No
Email	
Permission to communicate via email	☐ Yes ☐ No
Address	
Others that reside at the above address. Include: • Relationship to the child • Date of birth.	
Parent / Guardian 2	
Relationship to Child	

Phone number(s)	
Permission to leave a message	☐ Yes ☐ No
Email address	
Permission to communicate via email	☐ Yes ☐ No
Address	
Others that reside at the above address. Include: • Relationship to the child • Date of birth.	
Is there a parenting order in place? If yes, please provide brief details.	
Preferred contact person	
Emergency contact person for child	Name: Contact:
Referring General Practitioner	Name: Contact:
Medicare number. Please add the number next to the child's name in brackets.	
Does your child have any medical conditions?	☐ Yes ☐ No
If yes, please provide details	
Is your child on any medication?	☐ Yes ☐ No
If yes, please provide details	

Has your child ever been assessed by and/or received services from any of the professionals listed below?

	Ever Attended?	Name of Professional	Approximate Date of Service	Attending now?
Psychologist	☐ Yes ☐ No			☐ Yes ☐ No
Speech Therapist	☐ Yes ☐ No			☐ Yes ☐ No
Occupational Therapist	☐ Yes ☐ No			☐ Yes ☐ No
Paediatrician	☐ Yes ☐ No			☐ Yes ☐ No
Psychiatrist	☐ Yes ☐ No			☐ Yes ☐ No
Child and Youth Mental Health Services	☐ Yes ☐ No			☐ Yes ☐ No
Guidance Officer	☐ Yes ☐ No			☐ Yes ☐ No
Optometrist	☐ Yes ☐ No			☐ Yes ☐ No
Audiologist	☐ Yes ☐ No			☐ Yes ☐ No
Other	☐ Yes ☐ No			☐ Yes ☐ No

Please attach copies of all relevant reports.

PLEASE DESCRIBE ALL YOUR CURRENT CONCERNS ABOUT YOUR CHILD

Behavioural: willingness to follow instruction, response to limit setting, acting out, acts of verbal and/or physical aggression towards self or others, conduct issues

Emotional: overall emotional wellbeing, appropriateness of emotional responses, ability to self-regulate

Social: family relationships, friendships, play

Academic: learning needs, school work performance, motivation

Physical: sleep, diet, exercise, lifestyle, health, medical conditions

Additional comments?

What are your goals or expectations for treatment? What changes would you like to see occur as a result of you and your child working with a psychologist? Please describe, in order of priority.

Thank you.