CATHERINE LOTRIONTE

Psychological Counselling Service

Client Information
Surname:
First Name:
Address:
Phone Number: Mobile:
Email Address:
Date of Birth:
Emergency Contact:
Name:
Phone Number:
Relationship to client:
General Practitioner/Referring Doctor:
Name:
Address:
Phone Number:
Medicare Number: Ref#: Expiry Date:
Private Health Insurer (If Applicable):
Prescribed Medication (If Applicable):
Where did you hear about my practice?

I (insert name): have read and understood the cancelation policy, confidentiality statement, the APS Charter for Clients of Psychologists and am aware of my entitlements through Medicare:

Signature: _____ Date: _____

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