Life Choice NDIS Provider Wide Bay Burnett®

Mental Health Request Form

<table>
<tr><td colspan="6">PATIENT DETAILS</td></tr>
<tr><td>PATIENT NAME:</td><td colspan="2"></td><td>D.O.B:</td><td colspan="2">AGE:</td></tr>
<tr><td>ADDRESS:</td><td colspan="2"></td><td colspan="3">GENDER: ☐Male ☐Female ☐ Other</td></tr>
<tr><td>EMAIL:</td><td colspan="2"></td><td>PHONE:</td><td colspan="2"></td></tr>
<tr><td>PRIMARY DIAGNOSIS:</td><td colspan="5"></td></tr>
<tr><td>DO YOU IDENITY AS:</td><td colspan="5">☐ Aboriginal ☐ Torres Strait Islander ☐ Other ☐ None</td></tr>
<tr><td>MEDICARE NUMBER:</td><td colspan="2"></td><td>HEALTHCARE CARD/PENSION NO.</td><td colspan="2"></td></tr>
<tr><td>PRIVATE HEALTH DETAILS:</td><td>Health fund name:</td><td></td><td>Member Number:</td><td colspan="2"></td></tr>
<tr><td>RELEVANT DOCUMENTS:</td><td colspan="5">☐ GP Referral ☐ Mental Health Care Plan
☐ Other Documentation Attached* (please specify):
(e.g. please attach previous reports from allied health/ medical summaries where possible)</td></tr>
<tr><td colspan="6">CONTACTS:</td></tr>
<tr><td rowspan="2">PRIMARY CONTACT:</td><td colspan="2">Full Name:</td><td colspan="3">Relationship:</td></tr>
<tr><td colspan="2">Email:</td><td colspan="3">Phone:</td></tr>
<tr><td rowspan="2">SECONDARY CONTACT:</td><td colspan="2">Full Name:</td><td colspan="3">Relationship:</td></tr>
<tr><td colspan="2">Email:</td><td colspan="3">Phone:</td></tr>
<tr><td rowspan="3">GP:</td><td colspan="2">Name:</td><td colspan="3">Phone:</td></tr>
<tr><td colspan="2">Company:</td><td colspan="3" rowspan="2">Provider Number:</td></tr>
<tr><td colspan="2">Email:</td></tr>
<tr><td>SERVICE AGREEMENTS TO BE SENT TO:</td><td colspan="5">☐ Participant ☐ Primary contact ☐ Other</td></tr>
<tr><td>APPOINTMENTS TO BE MADE WITH:</td><td colspan="5">☐ Participant ☐ Primary contact ☐ Other</td></tr>
<tr><td>INVOICES TO BE SENT TO:</td><td colspan="5">☐ Participant ☐ Primary contact ☐ Other</td></tr>
</table>

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SERVICES BEING REQUESTED:		
REFFERAL TO:	NAME:	Johanne Hawke
	ADDRESS:	75 Lennox Street, Maryborough QLD 4650
	EMAIL ADDRESS:	alliedhealth@lifechoicewbb.org
	PHONE NUMBER:	07 4123 6288
	PROVIDER NUMBER:	4078374K
REASON FOR REFERRAL:		
ASSESSMENT/REPORTS REQUIRED: (if yes, please specify)	☐ Yes (please specify type): ___________________________________ Date required: ______________ ☐ No Additional comments:	
Additional Comments: *(please provide any other relevant information)*		

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CONSENT AND SERVICE AGREEMENT

PRICE GUIDE:	Service: Psychology	Item Code: 15_056_0128_1_3	Hourly Rate: $180

FUNDING CONFIRMATION:

I ________________________ (name of patient) agree to the rate of $180 per hour with a Medicare Rebate. I Consent to paying the gap between this quoted price of $180 per hour and the Medicare rebate. Life Choice cannot quote this rebate as this is devised by Medicare and can change. If you would like to know the current rebate please contact Medicare Australia for this information.

Client Signature: _______________________________ Date: ____________________

CANCELLATION POLICY:

Life Choice has a Short Notice Cancellation (or no show), they are able to claim 100% of the agreed fee associated with the activity. Where the patient has provided 48 business hours' notice (2 days) of the cancellation a fee will not apply.
No Notice or Notice of less than 48 business hours will have a fee applied to the value of the full price of the appointment.
I __________________ (name of patient) have read and agree to the cancellation policy and agree to pay the cancellation fee if no notice or less than 48 hours' notice is provided.

Client Signature: _______________________________ Date: ____________________

SERVICE AGREEMENT:

This agreement is between the patient and Life Choice, this agreement means to be a legally binding contract. This agreement will start on the date this document is signed. This agreement to service will continue to be valid for the life of your supports with Life Choice unless ended by either party.

What is expected of your provider?

We agree to:

- Review with you the provision of supports as required
- Once agreed, provide supports that meet your needs at times agreed with you
- Communicate openly and honestly with you in a timely manner
- Treat you with courtesy and respect
- Consult you on decisions about how supports are provided
- Give you information about managing any complaints or disagreements
- Give you details of our cancellation policy
- Listen to your feedback and resolve problems quickly
- Give you required 10 business days' notice if we have to end this Agreement
- Protect your privacy and confidential information in a manner consistent with all relevant laws, including the Privacy Act
- Provide supports in a manner consistent with all relevant laws
- Keep accurate records on the supports provided to you.

What is expected of you or your representative?

You (or your representative) agree to:

- Inform us about how you wish the supports to be delivered to meet your needs
- Manage and make appropriate arrangements for the management of payment for all supports you receive
- Treat us with courtesy and respect
- Talk to us if you have any concerns about the supports being provided

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	• Give us the required minimum notice of 10 business days if you need to end this Agreement. • We will send you an invoice for those supports for you to pay. You agree to keep your payment method details and contact details updated with us and to pay the invoice immediately after every session conducted. Client Signature: _________________________________ Date: _____________________
PRIVACY CONSENT:	By law, we require your consent to release or obtain any of your information. Please read this the below carefully and sign where indicated below. This practice obtains information from you for the primary purpose of providing quality health care. We ask that you help provide us with your personal information and medical history so that we can properly assess, diagnose, treat and be proactive in your health care needs. Your personal information will be used in the following ways: • Administrative purposes in running our practice. • Billing purposes, including compliance with Medicare Australia requirements. • Disclosure to others involved in your health care, including treating doctors and other medical specialists outside of this practice. • Disclosure for research and quality assurance activities to improve community and individual's health care. You will be informed of such activities prior to participation and you are given the opportunity to 'opt out' of any involvement. I have read and understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of my health care and treatment. I hereby consent to being a client of this practice and I confirm that I have read and that I agree to the above practice policies. Client Signature: _________________________________ Date: _____________________
REFERRAL COMPLETED BY:	Name: Relationship: Date:

NEXT STEPS	
Please send this document back to Life Choice filled out and signed	
EMAIL:	alliedhealth@lifechoicewbb.org
DROP OFF:	Hervey Bay office – 1/1-17 Hershel Court, Urraween Maryborough office – 75 Lennox Street, Maryborough
PROCESS:	Our Allied Health Admin team at Life Choice will process your referral and give you (or your representative) a call to book in an appointment with our Psychologist. ***Please allow 10 business days for you request to be fully processed.***

"Life Choice is not a crisis service, if you are experiencing a crisis and are at risk please call Lifeline on 13 11 14 or emergency services on 000 if required."

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