Client Details Form

CBT Canary Wharf

Cognitive-Behavioural Therapy Service

Telephone: (020) 7531-1220

E-mail: cbtcanarywharf@btinternet.com

www: cbtcanarywharf.co.uk

Surname: ______________________

Given names: ______________________

Date of Birth: ______________________

Address: ______________________

____

Select **Y** if I can leave you a message

Select **N** if you prefer I don't leave a message

			Y	N
Home phone no:	______________	messages:	Y	N
Mobile:	______________	messages:	Y	N
Work:	______________	messages:		N

Are you paying via your Health Insurance: Y N

(if Yes, who is your insurance provider?) ➔

If insured, please provide Membership Number and/ Claim/Authorization number:

Insurance Co: ______________

Membership # ______________

Claim #: ______________

How did you hear about me?

BABCP website

Counselling Directory website (www.counselling-directory.org.uk)

GP

my My website (www.cbtcanarywharf.co.uk)

Consultant Psychiatrist

Psy Other: ______________________

GP Details:
(***or*** referring Consultant Psychiatrist's details)

Name: ______________________

Address: ______________________

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Phone: ______________________

My signature below confirms that I have read and understood all the information detailed in the Therapy Contract (Terms and Conditions) and that I agree to abide by the Terms and Conditions outlined therein. In addition, I also understand that Marla Stromberg reserves the right to contact my GP, Consultant or other relevant external agencies if she believes I am a danger to myself or to others.

Signed: ______________________

Date: ______________________

Print name: ______________________

Consent to be contacted by Marla's Clinical Trustee

Clinical Will

As part of the BABCP's (British Association for Behavioural and Cognitive Psychotherapies) Standards of Conduct, Performance and Ethics policy, all BABCP Accredited therapists are now required to have arrangements in place for their clients to be informed and supported if something unexpected prevents a therapist from continuing their clinical work, i.e., if I become suddenly ill, incapacitated in any way, or die.

In case I am suddenly unable to continue to provide professional services to you, or to maintain client records due to incapacitation or death, I have designated a colleague as my Clinical Trustee. She is a BABCP Accredited CBT Therapist and is also my clinical supervisor.

If I die or become incapacitated and am no longer able to carry out my professional duties, my Clinical Trustee will be given access to my client records and she will contact you directly to inform you of my death or incapacity. She will discuss with you your preference to either continue therapy with another qualified therapist or professional, or to be discharged, should you so wish.

If you would like to be notified if I become incapacitated or die, you will need to provide consent to being contacted by my Clinical Trustee, Niki Trenchard.

I, ______________________________________ consent to being contacted by Niki, in the event Marla can no longer continue providing therapy to me, either due to incapacitation or death.

My preferred method of contact is:

Email: _________________________________

Phone: _________________________________

Signature: _________________________________

Date: _________________________________