

# Child & Family Intake Form



## Child and Family Information

Child's Name: \_\_\_\_\_

Sex assigned at birth: **Male / Female** (circle) Identifies as: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age at Referral: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(Street or PO Box) (City/State) (Post Code)

*If Mailing Address is PO Box, please provide physical address also:*

Parent (1) Full name: \_\_\_\_\_ Mobile: \_\_\_\_\_

E-mail: \_\_\_\_\_

Parent (2) Full name: \_\_\_\_\_ Mobile: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Primary contact for communication/correspondence/reminders:** Parent 1 / Parent 2/ both (please circle)

**If the child is subject to out-of-home living arrangements (i.e., Child Protection Orders), please **provide a copy** of guardianship or custody papers. No appointments will be booked if this information is not provided.**

Legal Guardian\* Full Name: \_\_\_\_\_ Mobile: \_\_\_\_\_

E-mail: \_\_\_\_\_

(\* Please indicate:  **Child Safety**^  Other family member  Other: \_\_\_\_\_)

^Please provide contact details of Child Safety Officer: \_\_\_\_\_

**Emergency Contact Details (if other than Parent 1 or Parent 2 listed above):**

Full name: \_\_\_\_\_ Mobile: \_\_\_\_\_

E-mail: \_\_\_\_\_

## Mandatory Information – Separated Families

Are there Consent Orders in place? **Yes / No / Pending** (circle)

Are both parents aware the child is attending our Clinic? **Yes / No** (circle)

Do both parents consent to the child accessing our Services? **Yes / No** (circle)

Please note: Consent Orders (if in place) must be supplied prior to engaging in our services.  
**BOTH** parents must sign the Intake Form if in agreement with accessing our services, *unless* otherwise specified in the Orders *or* a parent is uncontactable but not known to be opposed to the child's attendance to the Clinic (see Waiver, below).

## WAIVER – DUAL PARENT CONSENT

I, \_\_\_\_\_ am the mother/father/legal guardian of \_\_\_\_\_. I have made every attempt to contact the mother/father of \_\_\_\_\_ and have been unable to do so. I have informed them of attendance to Caterpillar Clinic by email/text/voicemail (circle). However, I was not able to obtain their written consent. To the best of my knowledge, I am not aware that they are opposed to attendance to Caterpillar Clinic. I understand Caterpillar Clinic requires parental consent from both parties and I am willing to accept full responsibility if I engage my child without the written consent of their mother/father/legal guardian. I acknowledge that should the child's records be subpoenaed in any future court proceedings, this information will be provided to the respective parties lawyers and/or Court Magistrate.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

## Claiming your Sessions

Please select from the below options to state how you intend to claim your sessions and fill out the relevant fields.

**Private** This is not processed in our clinic. You are required to claim through your Private Health.

Initial \_\_\_\_\_

**Medicare** You will require a mental health care plan (MHCP) from your GP to claim the rebate. Please **provide** your Medicare details below.

Initial \_\_\_\_\_

**NDIS** Please **provide** your NDIS details below.

Initial \_\_\_\_\_

## Medicare Details

**CHILD'S** Medicare Card Number: \_\_\_\_\_ (10 digits)

Expiry Date \_\_\_\_/\_\_\_\_

**CHILD'S** Number on Card: \_\_\_\_\_

**CLAIMANT'S** Name: \_\_\_\_\_

**CLAIMANT'S** Medicare Card Number (if different): \_\_\_\_\_ (10 digits) Expiry Date \_\_\_\_/\_\_\_\_

**CLAIMANT'S** Number on Card: \_\_\_\_\_ **CLAIMANTS D.O.B.** \_\_\_\_\_

**NOTE: The Claimant is the parent/guardian claiming the rebate from Medicare. Please ensure that your bank and personal details are correct and up to date on your Medicare profile. These details must be completed.**

## NDIS Details

NDIS Plan Start Date: \_\_/\_\_/\_\_

NDIS Participant Number \_\_\_\_\_

**Please tick how your plan is managed:**

- Self-managed
- Plan Managed (Plan Manager: \_\_\_\_\_)
- NDIA Managed

**\*Please provide a copy of your NDIS plan (financial details do not need to be shown). No appointments will be booked if this information is not provided.**

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## Reason for Referral

**Presenting Concerns** (include detailed information regarding psychiatric symptoms/behaviour problems/significant psychosocial stressors that may interfere with child/family function) **\*This must be filled out.**

## Child and Family Strengths

(Include individual strengths, family strengths, natural supports, and community linkages)

## Cultural and Religious Beliefs

We at Caterpillar Clinic believe that an understanding of our client's beliefs, values, customs, and preference is crucial to the development of a respectful relationship. Please take the time to provide us with any information you would like to share about those practices, beliefs, wishes or customs that you and your family value and would like us to understand when planning or providing support.

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Please list any **medications, vitamins or supplements** the child is currently taking and the dosage(s):

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<b>Current/Previous Diagnoses</b>	<b>Date Diagnosis Made</b>	<b>Diagnosing Doctor or Clinician</b>
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<hr/>	<hr/>	<hr/>

**Services Requested** (please check all that apply):

- Initial Consultation / Standard Psychology Sessions
- Diagnostic Evaluation (for autism, ADHD, and/or learning disorders)
- Early Intervention Program (autistic children aged 2-9 years)
- Other (please specify):

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***Please include any reports (diagnostic, assessment, progress) generated by any health, education, or private providers.***

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### Availability

Please select which days are your best availability. We understand that your child may be attending school during the weekday. However, we will aim to do our best to liaise suitable times with you when appointment availability arises.

- Monday       Tuesday       Wednesday       Thursday       Friday

**X** \_\_\_\_\_  
**Signature of Person Completing This Form**

\_\_\_\_\_  
**Date:**

**X** \_\_\_\_\_  
**Name of Person Completing This Form**

# Informed Consent

I am requesting services for \_\_\_\_\_ (child's name) by the Caterpillar Clinic Pty Ltd. I am legally responsible for him/her and have the authority to consent to the services because (please mark appropriate space):

- I am his/her PARENT.
- I am his/her LEGAL GUARDIAN. **Please include a copy of the guardianship papers.**

## Explanation of Consent:

- I understand that for services to be completed, I must consent to the services.
- I understand that my consent is voluntary and can be withdrawn at any time.
- I may withdraw my consent either verbally or in writing. However, consent cannot be withdrawn for any action previously taken, based on this consent.
- I understand that any information gathered before, during, and after services will be treated as confidential information.
- I understand that it is my right to get copies of any reports generated, if applicable. I also understand that I will be provided with copies as soon as possible after the services are provided, if applicable.
- I understand that this is an independent service. The recommendations should be implemented as appropriate and agreed upon between the family and any supporting agencies.
- I understand a photocopy of this form will have the same effect as an original.
- I understand staff from Caterpillar Clinic Pty Ltd will use electronic means (including but not limited to email, SMS, Halaxy, etc.) to communicate and gather information for the services I have requested.

Initial \_\_\_\_\_

**\*Please list names of any persons or providers you *do not* give consent to share information with. If at any point whilst using Caterpillar Clinics services if these details change, please provide the Administration and Psychologists with the changes in writing.**

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Initial \_\_\_\_\_

### Permission to Photograph and/or Videotape:

- I understand that the services conducted by Caterpillar Clinic Pty Ltd may be videoed, and we may be photographed. Videos are used to assist in diagnostic assessments and/or session work. Videos/photos are deleted once reviewed and/or uploaded into the client’s electronic file. This photo/video will not be released without my consent.
- **If I do not consent permission to photograph and/or videotape, I understand that I can mark an “X” through this paragraph. Please note that completion of an autism diagnostic assessment may be difficult without videoing the direct assessment of the child/young person.**

Initial \_\_\_\_\_

### Consent for Services:

- My consent is given freely and without coercion.
- I have been able to discuss any questions or concerns about this Informed Consent form with a staff member at Caterpillar Clinic Pty Ltd. This person has answered any questions I had.
- I understand that for services to be completed by Caterpillar Clinic Pty Ltd, I must consent to the conditions in this form. If I do not agree to the conditions in this form, Caterpillar Clinic staff will attempt to find another source for services.

Initial \_\_\_\_\_

### Specific entities I approve to contact for additional/supplementary information are:

- Queensland Health
- NDIA/NDIS
- Other:
- Education Queensland
- Private practitioners (specify)

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If wishing for your child’s school to be involved, please include their details below:

### School/Agency Information

School / Agency Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Current Teacher: \_\_\_\_\_

**Please list the name of the person we should contact at the school/agency to arrange the requested services and mail copies of reports to:**

Contact Person: \_\_\_\_\_ Position: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_@\_\_\_\_\_

### Disclaimers:

- Nothing in this form should be read to obligate Caterpillar Clinic to provide services.
- Services are scheduled and completed based on the clinical judgment of Caterpillar Clinic staff. These decisions are based on the appropriateness of the services in meeting the mission of Caterpillar Clinic and the appropriateness of the services in assisting the individual.
- Caterpillar Clinic reserves the right to refuse to provide services if the clinical staff determines that the services cannot be conducted appropriately by Caterpillar Clinic. In this case, Caterpillar Clinic staff will attempt to find another source of services.
- Ancillary supports (i.e., interpreters) to facilitate our part of the services are the responsibility (financially and scheduling) of the referring party.

Initial \_\_\_\_\_

I have **read** the above information, and note my/our **agreement** by signature below:

**X** \_\_\_\_\_  
Signature of Parent/Legal Guardian (1)

\_\_\_\_\_  
Date

**X** \_\_\_\_\_  
Name of Parent/Legal Guardian (1)

**X** \_\_\_\_\_  
Signature of Parent/Legal Guardian (2)

\_\_\_\_\_  
Date

**X** \_\_\_\_\_  
Name of Parent/Legal Guardian (2)

# Fee Information & Cancellation Policy

**You do not need a referral from a GP/paediatrician to access services by our Registered Psychologist unless you are interested in accessing government rebates or funding (i.e., Medicare Rebates).**

## Medicare

In consultation with your General Practitioner, Paediatrician or Psychiatrist, you may obtain a referral that enables eligible clients to receive rebates from Medicare for psychology sessions. This should be done before you obtain an appointment with Caterpillar Clinic. Mental Health Care Plans (MHCPs) usually allow the first six (6) sessions to be rebated under Medicare. After the 6<sup>th</sup> session, the treating psychologist will send a review to your referring GP at which time you will need to make an appointment with the GP to discuss this review. This is so the GP can release up to four (4) more sessions under that MHCP.

**\*Please note we are not a bulk billing service. Sessions used under mental health care plan are not 'free' and will have an out-of-pocket expense.**

## Private Health Funds

Most private health funds offer rebates on psychological, speech and occupational services if the client has ancillary or extras cover. Rebates vary depending on your fund and your level of cover. Please contact your health fund for the latest rebate information.

## NDIS

Caterpillar Clinic is a registered provider with the NDIA and approved to provide supports listed under Early Intervention Supports for Early Childhood, and Therapeutic Supports. Clients (participants) can be agency-, Plan-, or self-managed. All participants are required to attend an Initial Consultation after which a Service Agreement will be completed specifying supports to be provided, frequency, and total cost.

Our NDIS Fee Schedule has been set based upon the 2023 NDIS Price Guide. Our services are below the recommended fees outlined in the Price Guide; however, each participant's Plan and funding is calculated from the Price Guide (i.e., NDIS Planners use the NDIS Price Guide when calculating the funding to be allocated towards the Participant's Plan). That means that funding allocated should be more than sufficient to cover our Clinic's psychology and behaviour therapy supports that we have recommended for you in NDIS Support Letters/Plan Reviews.

Our NDIS Prices are higher than our standard Clinic-prices. This is because of the additional work and reporting requirements that occur with NDIS participants. There are significant administration costs associated with being an NDIS Provider, which we can only recoup through hourly fees. Further, we acknowledge that Medicare families are personally paying an out-of-pocket cost for our service and have a limited number of rebate able sessions, so have tried to be as reasonable with fees as financially possible for our Clinic to allow greater access as possible.



## Cancellation Policy

*Please familiarise yourself with our Clinic's policy on cancellations.*

As we are a busy clinic with psychologists working at capacity with the whole hour (or more) reserved for you when you make an appointment. We require at least **48 hours' notice** should you wish to cancel or reschedule. This allows us to offer your appointment to clients on our extensive waitlist.

**Cancellation fees for Medicare or Privately billed/Connect to Wellbeing clients will incur the following:**

- Less than 48 hours' notice will result in a charge of 50% of the service fee.
- 'No Shows' with no phone call or SMS will result in a fee of 100% of the service fee.
- Three (3) cancellations in three (3) months without rebooking will result in the cancellation of any remaining pre-booked sessions and your child will be placed onto our waitlist.
- Three (3) cancellations in a row will result in disengagement from the Clinic.

**Any cancellation fees incurred will require payment before any subsequent sessions can be booked/attended.**

**Cancellation fees for NDIS Clients are based upon the NDIA Guidelines and are the following:**

- Less than 48 hours' notice will result in a charge of 100% of the fee.
- 'No Shows' with no phone call or SMS will result in a Charge of 100% of the fee.
- Three (3) cancellations in three (3) months without rebooking will result in the cancellation of any remaining pre-booked sessions and your child will be placed onto our waitlist.
- Three (3) cancellations in a row will result in disengagement from the Clinic.

Sessions are payable by Visa, Mastercard, Cash (not preferred but do accept) or online bank transfer. Please note that rebates and fees are subject to an annual increase.

Please note NDIS Self-Managed Clients are required to pay for the sessions on the day unless discussed with administrative staff prior. Please see the attached Self-Managed Policy.

**\*I have read the above information and note by signature below, I acknowledge and agree to adhere to Caterpillar Clinic's Cancellation Policy.**

**X**  
\_\_\_\_\_  
Signature of Parent/Legal Guardian (1)

\_\_\_\_\_  
Date

**X**  
\_\_\_\_\_  
Signature of Parent/Legal Guardian (2)

\_\_\_\_\_  
Date

**Postal:** PO Box 830 | Bungalow QLD 4870  
**Physical:** 4/161 Aumuller Street, Bungalow QLD 4870  
**P:** 07 4281 6886 | **E:** [admin@caterpillarclinic.com.au](mailto:admin@caterpillarclinic.com.au)

## Booking Terms and Conditions

Our Clinic has the following terms and conditions when booking appointments.

Credit card details must be supplied to the Clinic to confirm any/all bookings that are paid by the consenting adult/parent/service (i.e., full fee-paying clients, Medicare clients, or self-funded NDIS clients). This card will only be charged once the appointment has been attended or if the terms of the Cancellation Policy are met (i.e., if the Clinic does not receive 48 hours' notice of non-attendance, or a confirmed appointment is not attended). In these instances, we reserve the right to automatically charge the appropriate fee to the card on file.

We do understand that emergencies occur, and this will be taken into consideration. If you are charged for late cancellation or non-attendance, you can request an Objection to Charge Form from administration and this will be submitted to our Clinical Director for review. If authorised by our Clinical Director, a refund will be administered accordingly.

Please supply your card details below:

Name on Card: \_\_\_\_\_

Card Number: \_\_\_\_\_

Expiry Date: \_\_\_\_\_

CCV: \_\_\_\_\_

**Please Note:** This information will be securely stored into our encrypted software system for invoice management and this document will be appropriately destroyed once uploaded to our secure server.

**I have read the above information and note by signature below, I acknowledge and agree to adhere to Caterpillar Clinic's Booking Terms and Conditions.**

X \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent/Legal Guardian (1)

X \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent/Legal Guardian (2)