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Solstice-Mind Matters PTY Ltd Trustee
for the Solstice Discretionary Trust
ACN: 107 4 72720 ABN: 67 664 403 107

CLIENT INFORMATION FORM

❑ Child ❑ Adolescent ❑ Adult ❑ Family ❑ Couple

Name: Dr/Mr/Mrs/Miss/Ms/Master (Circle) First Name(s) Surname(s)

DOB: **Female/ Male** (Circle) **Enthic Orientation:**

(if child please provide parent/carer/guardian Full Name **DOB:**

Address:

Contact: **(Please tick preferred method of contact)**

Home Phone: o Mobile: o Work: o

Email: o

Do you require assistance with communication (please tick) **Yes** o **No** o

If yes; please advise

Medicare No. _ _ _ _ _ _ _ _ _ _ _ _ **(position on card) Valid To:** _ _ / _ _ _ _

Nominated Payer: **(Parent/Carer must be listed as 'payer' if child under 12)**

Medicare No. _ _ _ _ _ _ _ _ _ _ _ _ **(position on card) Valid To:** _ _ / _ _ _ _

Next of Kin/Emergency Contact: Phone:

Referred by: **(or how did you find us)**

Fee Rebate: MBF, Medibank Private, Other:

Billing Organization (please include contact details

Work Information:

Family Information:

Additional Information: (e.g. test results)

- ***Courtesy requires that at all times, both clients and clinicians maintain a respectful attitude and manner of interaction towards each other.***
- ***I / We understand that a 48 hour notice of cancellation is required for any appointment and failure to do so will incur the appointment charge.***

SIGN: :DATE:

(see reverse side for privacy policy)