

## **Lyn McIntosh**

**Clinical Psychologist & Family Therapist**

Assoc Dip (Wel), BA (Soc Sci), Grad Dip (Ed) Psych, M (Couns) Psych,  
Dip (Clin Hyp), Grad Dip Fam Th, MASH, MAACH, MAPS, AAFT Clinical Member

**Windsor 3181**

**Camberwell 3124**

**P. O. Box 7 Glenhuntly 3163**

**Mobile 0409 578 054**

**HIC 2669441J**

**HIC 2669447B**

**WCC 00226459-02**

**ABN 91 250 974 278**

### **Personal Details Form**

**Ref No: 14 /**

**Surname: ..... Given Names: ..... DOB/Age: .....**

**Surname: ..... Given Names: ..... DOB/Age: .....**

**Address: .....**

**Phone Numbers: Home: ..... Work: ..... Mobile: .....**

**OK to leave message on Phone Numbers? Home: Yes /No Work: Yes /No Mobile: Yes /No**

**Children: Names: ..... DOB/Age: .....**

**Names: ..... DOB/Age: .....**

**Names: ..... DOB/Age: .....**

**Next of Kin: Name: Address: Phone: .....**

**Doctor: Name: ..... Address: .....**

**..... Phone: ..... Permission to Contact: Yes /No**

**Private Health Insurance / Pension or Health Care Card / D.V.A. Number: .....**

**Referral Source: / Doctor / Friend / School / Phone Book / Internet /**

**Referral Type: GP 2710 Medicare      Personal      TAC      WorkCover      VOCAT**

**Referral No: ..... Referral/Injury Court Date: .....**

**Payment of Account: I agree that, unless otherwise stated and agreed, I am responsible for payment of my account at the time of consultation. I agree that all other costs associated with my treatment [eg court reports, etc] are also payable by me at the time of service. As 48 hours / 2 working days notice is required for appointment cancellation; I agree to pay any late cancellation fee for failure to attend appointments or cancel within the expected time.**

**Signed ..... Dated .....**

**Signed ..... Dated .....**