THE
MIND
FACULTYΨ
Psychiatry & Psychology Medical Center

REGISTRATION FORM

This form shall be completed and signed by you prior to you seeing any of The Mind Faculty's Psychiatrist / Counselor / Psychologist / Therapist and you shall enclose a copy of your valid National Identity Card if you are a Malaysian, Passport if you are a foreigner (front and back view).

If you are below 18 years old of age, this form shall be signed by your PARENT or LEGAL GUARDIAN (A copy of the birth certificate or court order for appointment of guardian is enclosed herewith).

PATIENT's PARTICULARS

Given name (As in *NRIC/Passport): ____

NRIC/Passport No : ____

Date of Birth : ____

Gender: ____

Corresponding Address: ____
____
____
Postcode : State :
Country :

Permanent Address: ____
____
____
Postcode : State :
Country :

Date and Time of Registration: ____

Phone No: (o)__________________(hp)________________

Email: (o)__________________(private)_____________

THE MIND FACULTY SDN BHD (988290-W)
Suite 11-G & 11-1, Jalan Solaris 4, Solaris Mon't Kiara, Jalan Solaris
Off Jalan Duta Kiara, 50480 Kuala Lumpur
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PARENT's OR LEGAL GUARDIANs PARTICULARS

Given name (As in *NRIC/Passport) : ______________________________________

NRIC/Passport No: ______________________________________

Corresponding Address: ____
____
____
Postcode : State :
Country :

Permanent Address: ____
____
____
Postcode : State :
Country :

Date and Time of Registration: ____

Phone No: (o)__________________(hp)________________

Email: (o)__________________(private)____________

EMERGENCY CONTACT DETAILS

Given name in *NRIC/Passport): ____

Corresponding Address: ____
____
____
Postcode : State :
Country :

Phone No: (o)__________________(hp)________________

Email: (o)__________________(private)____________

TERMS AND CONDITIONS:-

I hereby declare and acknowledge that I have read, agreed and fully understood the following and I had sought independent legal advice towards the same and that confirm and acknowledge:

1) that you provide psychotropic medications and other therapeutic interventions (collectively known as "Treatments"). These therapeutic interventions are conducted with physical consultation and / or through information and communication technologies (ICT – electronic communication). The latter is referred to as telemedicine services; and
2) that I am seeking all or some or any of the Treatments from you at my own free will; and
3) that the Treatments as stated in (2) that I am seeking serves to assist, to promote and improve my well-being and coping skills in dealing with my situation; and
4) All fees for the Treatments as stated in (2) shall be payable after each session via cash or credit card only and a prepayment will be required for Telemedicine services; and
5) that I will be charged cancellation charges equivalent to a session that such Psychiatrist / counsellor / psychologist / therapist may charge if I had attended the session with him / her in the event that an appointment made by me is cancelled by me with less than Twenty-four (24) hours notice given by me; and
6) that I won't be allowed any more session with any of The Mind Faculty's Psychiatrist / Consultant / Counsellor / Psychologist / Therapist if I have arrears owing to you; and
7) any adverse reactions to the therapy or medication are part of the treatment effect and you shall not be liable for such effects that may happen to me; and
8) any request for a medical report shall be made by me in written form and shall be collected by me personally; and
9) you are given irrevocably and unconditionally consent to release my medical report to any party as may be directed in response to an order of court or if disclosure is otherwise required by law; and

10) I hereby inform you of my previous medical history and are pleased to furnish to you herewith a copy of my medical records; and

____

11) you are given irrevocably and unconditionally consent to liaise with my previous Psychiatrist / Consultant / Counsellor / Psychologist / therapist for my medical history / medical report; and

12) I am allergic to the following medication / psychotropic medication:

____

13) I hereby grant/do not grant you permission to record all sessions I have with the Psychiatrist / Consultant/ Counsellor / Psychologist / Therapist and I shall have no access to any of the recordings of the CCTV and understand that you have the proprietary rights over the same; and
14) I disclaim you from all liabilities arising from the Treatments whether directly or indirectly and agree to indemnify you or keep you indemnified against all claims, costs, damages that you may suffer as a result of my withholding any information or furnishing you with inaccurate information or due to my omission in not disclosing material information to you; and
15) The Treatments and services (including telemedicine services) provided in this centre are govern under the laws of Malaysia.

Signature :
(Note : to be signed by Parents / Guardian if client is below 18 years old)

Date :

Name :

NRIC / Passport No :

Counter checked by:
Name of Psychiatrist / Counsellor / Psychologist / Therapist:

Signature: