**Service provider agreement**

I confirm that I will meet the following requirements for delivering Redress Counselling and Psychological Care;

**Prior to delivering the service, I will:**

[ ]  Verify, with permission, that the person receiving the counselling has an eligible Unique Redress ID and the number of counselling hours that are available.

[ ]  Disclose to the person any current or former association I or my organisation has with institutions participating in the National Redress Scheme or named in the Royal Commission into Institutional Responses to Child Sexual Abuse.

[ ]  Not require the person to complete an application form disclosing their experience of institutional child sexual abuse to access my service.

**In delivery the service, I will:**

[ ]  Consult with the person to determine their preferences and priorities in developing a counselling plan.

[ ]  *Consider the specific needs of the person such as needs related to their cultural background, disability, gender, sexuality and language.*

[ ]  *Provide the person with reminders about appointments and have in place a fair, reasonable and trauma-informed policy for the billing of unattended appointments that some people may have additional challenges when engaging with counselling and psychological care services.*

**In billing for this service, I will:**

[ ]  Charge the standard rate for this type of service within the limit for reimbursement.

[ ]  Identify on each invoice how many hours or minutes were provided and at what rate.

[ ]  Charge for Redress Counselling independently from health insurance and Medicare.

[ ]  Not charge the person a gap fee.

**If required, I will:**

[ ]  *Support people with complex and additional needs with referrals to appropriate providers with specialist expertise.*

[ ]  Support people to access additional therapeutic services, where needed, upon completion of their redress counselling.

**If billing for unattended appointments, then I will provide:**

[ ]  A copy of our policy on unattended appointments, and

*[ ]*  Evidence that the appointment was booked and that the person was reminded.

***Verified by the counselling/psychological care provider***

*Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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