Prior to issuing your first invoice for payment, this form must completed and signed by the counselling and psychological care provider, and must be submitted to the **Redress Counselling Program Team** at redresscounselling@dcssds.qld.gov.au.

|  |  |
| --- | --- |
| Counselling and psychological care provider name: |  |
| Practice Name: |  |
| ABN: |  |
| Bank account name: |  |
| BSB: |  |
| Account number: |  |
| Physical address: |  |
| PO Box (only if it is different to the physical address): |  |
| Contact person: |  |
| Contact number: |  |
| Email address: |  |
| Website (if applicable): |  |

### I hereby declare that the information in this form is true and correct.

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name (please print): ­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

#### Privacy Statement

The Department of Families, Seniors, Disability Services and Child Safety is collecting your personal information for the purposes of administering funds for services provided. The department is committed to protecting your privacy and manages personal information in accordance with the Information Privacy Principles and other obligations contained in the *Information Privacy Act 2009* (Qld).