**SERVICE BOOKING REQUEST**

 **Date of Booking Request:** 7 August 2020

**CLIENT INFORMATION:**

|  |  |
| --- | --- |
| **NDIS Number:** |  |
| **Participant Name:** |  |
| **Participant Address:** |  |
| **Contact Name, Phone, Email:** |  |
| **Date of Birth:** |  |

**SUPPORT COORDINATOR INFORMATION:**

|  |  |
| --- | --- |
| **NDIS Support Coordinator:** |  |
| **Organisation:** |  |
| **Email:** |  |
| **Phone:** |  |

**SERVICE BOOKING REQUEST INFORMATION:**

|  |  |
| --- | --- |
| **Service Organisation:** | Superbia Allied Health |
| **Line Item of Service:** | Occupational Therapy [ ] Speech Therapy [ ] Physiotherapy [ ] Psychology [ ] Exercise Physiology [ ] Art Therapy [ ]  |
| **Funds Allocated:** | (please enter line item and/or description) |
| **Hours/Period/Breakdown:** | Please indicate the budget allocated for allied health services\*All costs are in alignment with the 2019/20 NDIS Price Guide and are as follows: |
| **Service Booking Start Date:** |  |
| **Service Booking End Date:** |  |
| **Funds Management:** | NDIS Managed / Plan Management / Self Managed**Email invoices to:****Please CC emails to:**(insert Support Coordinators email) |
| **3rd Party Authorisation (\*Only required for Delivery Service)**  | By signing this Third Party Authorisation Form, I am making the following statements:I;* Authorise Superbia Allied Health to provide the Authorised Representative nominated in the section below with details of my account as listed above.
* Understand that this does not allow the Authorised Representative to change my details in any way, but in turn allows the Authorised Representative to present and perform transactions on my behalf.
* Agree to my information being used in accordance with Superbia Allied Health’s Privacy Policy.
* Acknowledge that I can revoke this authorisation at any time by verbal or written confirmation to Superbia Allied Health.

Complete the below date if you wish to limit the duration of this authority. Otherwise, this authority will be valid until you revoke it, or Superbia Allied Health advises you of their intent to cease services. This 3rd Party Authorisation is valid until: **NDIS Participant / Participants Representative Signature:****Date:** |
| **Authorised Representative Name:** |  |
| **Authorised Representative Address:** |  |
| **Authorised Representative Phone & Email Address:** |  |
| **Authorised Representative Signature:** |  |

Please email all service requests to alliedhealth@superbia.net.au