NEW PATIENT REGISTRATION FORM

TITLE ______ FIRST NAME ______ SURNAME ______

ADDRESS ______ POSTCODE ______

DATE OF BIRTH / / ______ EMAIL ______

TEL HOME ______ MOBILE ______

HOW DID YOU HEAR ABOUT THIS CLINIC?

- ☐ GP
- ☐ CONSULTANT
- ☐ INTERNET
- ☐ PREVIOUS PATIENT RECOMMENDATION. NAME: ______
- ☐ OTHER: ______

BODY PART BEING TREATED ______

OCCUPATION ______

GP/CONSULTANT

GP NAME AND ADDRESS ______

CONSULTANT NAME (IF APPLICABLE) ______

If you would prefer us not to write to your GP/consultant please tick the box ☐

INSURANCE

We only have direct billing agreements with **BUPA** and **AXA/PPP** .
Please obtain an insurance form from reception if you are claiming through one of these insurers.

Other insurers: Payment must be made at each visit. We will provide an itemised invoice in order for you to claim reimbursement directly.

CONSENT AND CANCELLATION POLICY

I understand that I am responsible for the full cost of my treatment, and agree to pay the fees for treatment at the end of each appointment.

I understand that should I fail to attend an appointment without 24 hours notice I will be liable for the full cost of the treatment.

SIGNATURE ______ DATE / /