

REGISTRATION AND CONSENT FORM

## (Sports and Musculoskeletal Medicine) Orchard Health Centre

**Welcome to the Orchard Health Clinic**

Please complete this form as accurately as possible. The information will be held on file and is subject to the same confidentiality as your medical records.

# Your personal details

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| **Patient Information** |
| Title: | **Mr / Mrs / Miss / Ms**       | Home Telephone: |       |
| Forename(s): |       | Mobile Telephone: |       |
| Surname: |       | Email Address: |       |
| Date of Birth: |       |  |

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| **Home Address** |
| Home Address: |       |
| Post Code: |       |

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| **Private Medical Insurance** |
| Insurer: |       |
| Membership Number: |       | Authorisation Number: |        |

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| **Where did you hear about us?** |
| GP/Consultant |       | Insurance company |       |
| Physiotherapist |       | Recommended by a friend |       |
| Chiropractor / Osteopath |       | Other, please specify |       |

# Consent

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| **It is standard procedure for us to inform your GP of your attendance at our clinic** |
| Yes, I do give my consent for relevant correspondence to be sent to my GP |       |
| No, I do not give my consent for relevant correspondence to be sent to my GP |       |

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| --- | --- | --- | --- |
| GP Name: |       | Telephone Number: |       |
| Address: |        |

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| **In some circumstances we may need to provide your insurance company with details of the treatment you are receiving by the way of a report. A copy can be made available at your request** |
| Yes, I do give my consent for relevant correspondence to be sent to my insurer |       |
| No, I do not give my consent for relevant correspondence to be sent to my insurer |       |

If you feel that you’d rather not share this report, then you are free to refuse consent; however, you should be aware that in doing

so, you will risk having to fund additional sessions yourself.

#  Your appointment

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| **During your appointment, the clinician will take a verbal history, perform a physical assessment and may suggest further diagnostic tests.** |

During your appointment you are more than welcome to:

* be accompanied by a friend or relative
* ask us to provide a chaperone (see chaperone policy at reception)
* decline any diagnostic tests

If you have any questions at any point throughout the course of your appointment, please do not hesitate to ask.

# Your Personal Information (Data Protection and Patient Privacy)

The information collected on this application form will be used by Orchard Health Centre for purposes of healthcare related services and practice administration. This may require your personal data including, relevant details of your medical history, to be shared with other approved healthcare providers for the purpose of referrals and for other lawful purposes related to the Practice procedures.

Orchard Health Centre fully complies with Data Protection Legislation and Medical Confidentiality Guidelines. We recognise that when you give us personal information (which includes health information) you’re trusting us to take good care of it. Further information on how we collect, use and protect your data can be found in **Orchard Health Centre Data Protection and Privacy Notice**. Please ask for a copy at reception.

Please indicate if you consent to this.

Yes, I give permission for limited contact information to be shared

No, I do not give permission for my contact details to be shared

# Payment Consent

It is important that you contact your insurers to ensure that any treatment has been authorized. In most cases Private Medical Insurance does not cover the cost of medical supplies that may be required for your treatment (orthotics, braces etc).

A cancellation charge equal to the full cost of the appointment will be made if insufficient notice is given. For all appointments, 24 hours (working days only) notice is required.

I agree to pay Orchard Health Centre for the services if I do not have private medical insurance or an arrangement with any other third party, and for any charges that are my responsibility (e.g. cancellation fees, insurance scheme excess, benefit limit or exclusions). I agree to provide my credit/debit card details and I authorise Orchard Health Centre to charge my card for any charges incurred as above.

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| Signed:       | Print Name:       | Dated:       |