REGISTRATION FORM (Please use Block Capitals)

Information collected during the course of your treatment at Physio for All will remain strictly confidential under the Data Protection Act 1998

Title: …… First Name: ……

Surname: ……

Address: ……

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Post Code: ……Date of birth: …… /……/……

Home Tel: ……Work Tel: ……

Mobile: ……E-mail: ……

How did you hear about our clinic?

☐Doctor/Consultant/Other therapist (Name): …… ☐ Live locally ☐ Patient/WOM

☐Fitness instructor (Name): …… ☐Advert (please specify): ……

☐Insurance company (Name): …… ☐Internet search: ……

Other (specify): ……

Name and address of **NHS GP**: ……

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Name and address of **Private GP**: ……

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Name and address of **Consultant**:……

Have you been medically referred for your present complaint? ☐ Yes ☐ No

If 'yes' was it: ☐ by a doctor ☐ by a consultant Name of referrer: ……

Do we have your permission to forward correspondence to your doctors: ☐Yes ☐No

Preferred method of communication: Telephone ☐ Email ☐

Do you wish to receive an appointment reminder by email: Yes☐ No☐

We may wish to contact you from time to time with information about the services we offer or the latest relevant medical research. Please tick if you do not wish to receive this: ☐

Payment

The cost of your treatment is payable on the day of your treatment.
If you require a receipt to claim the cost from your insurance company we are happy to provide this.

Do you have private **medical insurance**? ☐ No ☐ Bupa ☐ Axa PPP ☐ Other: ……

If you wish to claim your treatment costs or part of it from your health insurance company, we would advise you to ensure in advance that your treatment is covered, as you may need to be referred by a doctor or consultant before receiving treatment.

Cancellation Policy

If you miss, cancel or reschedule an appointment with less than **24 hours notice** you will be asked to pay the full cost of the treatment fee. This is to avoid denying appointments to patients who may be on the waiting list and to enable us to optimize use of our therapists clinical time.

Declaration

I the undersigned, acknowledge and agree to full and final responsibility for the settlement of my accounts not withstanding any agreement to settle my accounts by a third party. I also understand that I will be charged a 100% cancellation fee if I fail to give 24 hours notice or fail to attend an appointment.

Signature: …… Date……

First Name and Surname of Parent/Guardian for a minor: ……

First Name, Surname and address of Payer if different from above: ……

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