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REGISTRATION FORM

Patient details

Name: ………………………………………………………………………………………………… Mr/Mrs/Ms/Dr/Other

Date of Birth: ……….

Address: …….

………

Contact number: ……………………………………………………...

E-mail: …….

How did you hear about us?..

Important information: Please tick boxes applicable

- ❑ Are you happy for us to contact you and leave a message if necessary?
- ❑ Are you happy for us to contact you by email for appointment purposes?
- ❑ You are happy for your email to be used for marketing material and other information.

GP name/surgery address: ……………………………………………………………………………………………

Consultant name (if applicable): …………………………………………………………………………………………

In case of emergency - named contact: ……………………………………………………………..

Relationship to the patient: ……………………………… Telephone number:………………………………

Financial agreement

I accept and acknowledge that I am liable for the payment of services received, and understand that payment for all services must be made after each treatment by either cash, card or cheque. If the practitioner has an arrangement with your insurer to receive directly from them, I the patient will remain responsible for all amounts due for a treatment not settled for whatever reason by the insurer. I understand and agree that a cancellation of an appointment with less than 24 hours notice will incur the full cost of the session.

I the undersigned have filled in all details correctly and to the best of my knowledge.

Signature: .... (of guardian where applicable)

Name: ……………………………………………………………………………… Date: ………………………………………

Please turn over and complete the next sheet