Integratedhealth

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The Wigmore Clinic
22A Wigmore Street
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PRIVATE MEDICAL INSURANCE SUPPLEMENTARY PAYMENT

I, ________________________________ agree to pay the additional fee of

£__________________ for treatment with Integrated Health.

I agree to this because I would like my treatment to be extended beyond that of what my health insurance provider (Name of insurance: ______________) will fund. It is solely my choice and I understand that I cannot reclaim this money from my private health insurance provider.

I would like the additional payment to apply to: *(please tick)*

- ○ All my sessions
- ○ Just one session (refer to date below)

Signature: ________________________________ (patient)

Date: _________________________________

Therapist: ________________________________