www.integratedh.com
+44 (0) 7543 533 497

www.nickyellis.org
+44 (0) 7599 345 843

REGISTRATION FORM

Patient details:

Name: …… Mr/Mrs/Ms/Dr/Other

Date of Birth: ……

Address: ……

…… Postcode:……

Contact number: ……

E-mail: ……

GP name/surgery address: ……

In case of emergency - named contact: ……

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

How did you hear about us?……

Data Protection agreement: We take security of your data very seriously. To ensure we protect you and comply with the law please tick the 3 boxes below otherwise we are unable to treat you!

- ❑ The creating and storing medical records concerning my treatment, which may include details concerning my medication, treatment and other issues affecting my health conditions, in accordance with the General Data Protection Regulation (GDPR) 2018.
- ❑ I understand that these records will be retained for eight years, (or until I reach 25 in the case of someone aged 16 - 18), when treatment ceases in order to comply with legal guidelines.
- ❑ I understand that these records will be processed in accordance with your *Privacy Notice* - a copy of which I have seen. The notice can be viewed on the base of this clipboard, our websites or in the 'patient information pack' in the waiting area.

We are required by law to obtain permission to contact you. It would be really helpful if you would agree to ALL of the following. None of these options are for marketing purposes.

- ❑ **TELEPHONE** - in case we need to discuss your treatment or diagnosis with you.
- ❑ **TEXT MESSAGE**- to send you appointment confirmation/reminders, or if some one cancels we can let you know a space has become available.
- ❑ **EMAIL** - to send you appointment information.
- ❑ **POST** - in case we need to post you a medical letter.

OTHER- If appropriate, do you consent to us contacting other health care professionals involved in your care? Please tick applicable box:

[ ] Yes [ ] No [ ] I would like to discuss it with you first

FYI: We are required by law to encrypt our emails if they contain any information about your care. To open emails you will need to create a free Egress account www.egress.com. Apologies for any inconvenience this may cause, it isn't us, it is the law!

PLEASE TURN OVER

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 cash, card or cheque. I understand and agree that a cancellation of an appointment with less than 24 hours' notice will incur the full cost of the session. If the practitioner is required to invoice a 3rd party e.g. employer or private medical insurer to receive payment directly from them, I, the patient, will remain responsible for all amounts due for a treatment not settled for whatever reason by the insurer.

Do you consent to us contacting a 3rd party regarding payment? [ ] Yes [ ] No

Promotional Information. We would like to stay in touch with you with information that may be of interest. How would you like us to contact you? Please tick applicable box:

[ ] Email [ ] Text message [ ] Do NOT contact me

We use a blend of treatments, please tick if you are happy for us to shift between treatments and notify you when we do so. [ ] Yes [ ] No

Acupuncture: We may use acupuncture as part of your treatment. Please tick applicable box:

- ❑ Yes, I am happy to have acupuncture (please fill out acupuncture screen questions below)
- ❑ I would like to think about it and discuss it with you first (more information overleaf)
- ❑ No thank you, I would prefer not to have acupuncture

Our policy can be found on our websites and 'patient information pack' in the waiting area. You can change your mind about having acupuncture at any time.

Acupuncture Screen:	**YES**	**NO**
1. Have you received any acupuncture treatment before?	[ ]	[ ]
2. If YES, did you have any unusual reactions? Please describe……..		
3. Do you have a medical condition e.g. haemophilia, hepatitis, HIV, diabetes?	[ ]	[ ]
4. If YES please state ……		
5. Do you regularly give blood?	[ ]	[ ]
6. Are you on any medication that the therapist should be aware of e.g. Warfarin	[ ]	[ ]
7. Are you pregnant or actively trying to get pregnant?	[ ]	[ ]
8. Do you know of any reason why you should not have acupuncture e.g. allergy?	[ ]	[ ]

If you have agreed to acupuncture, then signing below acknowledges you understand the purpose, benefits and risks of acupuncture and you consent to treatment. Please see "Should I try acupuncture?" information leaflet overleaf.

I have read and understood **ALL** the above information: Data protection /Financial Agreement/ Acupuncture, and am happy to give my explicit consent:

Patient name: ……

Signed …… Date: ……..

IF YOU ARE **UNDER 16** YEARS OF AGE, YOUR PARENT/GUARDIAN **MUST** SIGN BELOW

Name of parent/guardian:……

Signature: ..... Date: ……..