Agnieszka Kubalica, 14 Columbia Drive, Milton Keynes, MK8 1GE; Mobile 07927 922 304 Company No. 15937752

REGISTRATION FORM WITH TERMS OF ENGAGEMENT -

NEURO PHYSIO DIRECT LTD

PATIENT DETAILS (parent/guardian details if the client is a child or dependent)		
Name		Private health insurance Y /N
Surname		Health Insurance company
Date of birth		Authorisation code:
		Insurance Policy Number:
Address: Postcode		Phone number: Email:

EMERGENCY CONTACT DETAILS

Name	Relation to the client
Surname	Phone number
Address Postcode	Email:

Where have you heard about our services?

Professionalist …… GP …… others……

GENERAL PRACTIONER	CONSULTANT
Address	Address

Non- attendance or cancellation policy

I ask that if you cannot make your scheduled appointment, you contact us as early as possible. It will ensure other people do not miss out on available dates. The failure to give me 24 hours' notice before the appointment time the full charge for the appointment will be levied unless exceptional circumstances apply.

No or late payment policy

In a situation that there is an outstanding balance after the due date the company reserves the right to start applying late payment fees of 5% outstanding balance per month or £50 late payment fee whatever is higher.

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The payment options

The charges for the treatment could be fulfilled by cash, cheque, BACS or the card payment (please note that only VISA and Maestro are accepted).

Complaint procedures

If you have any complaints, please contact Mrs Kubalica by phone on 07927 922304 or at contact@neurophysiodirect.uk or akubalica82@gmail.com.

Discharge report

As a good practice, your physiotherapist may issue a discharge report addressed to your general practitioner or consultant. If you do not wish that to happen, please inform your physiotherapist.

Privacy Patient Information

My practice undertakes research, professional development, and quality assurance/improvement activities to provide a high standard of medical care. Any person accessing personal health information has signed a written confidentiality agreement.

I consent to my health record being reviewed as part of the quality improvement activities at this practice

Yes **No**

Some of your medical information may need to be shared with other health care providers. Our practice will only share relevant information to your care and with your consent.

I consent to sharing my medical information with other professionals as relevant to my care.

Yes **No**

Media: Video/audio recording & photography Permission

Part of providing a high level of quality service is being able to share information to help others in a similar situation and only where appropriate.

I _____ , the undersigned, permit Mrs Agnieszka Kubalica to keep video/audio recordings/ photos for teaching, treatment and research purposes.

I have read and understood all of the above.

Signature of patient or guardian_____Date / /