REGISTRATION & CONSENT FORM

Please note that treatment consent and GDPR consent are essential requirements for us to be able provide our services. If you do not tick these fields and we will not be able to treat you.

Title: _____ First Name: _____ Surname: _____

Date of Birth: _____

Address: _____

_____ Postcode: _____

Contact Details: Home Tel No: _____ Mobile: _____

We will use your mobile telephone number to send you text reminders of your appointments.

Email address (optional): _____

We will use your email address to send you reminders of your appointments.

Doctors Details:

GP Name: _____ Practice Name: _____

Method of Payment: Self Pay or Insurance Company (Please highlight)
Please complete health insurance form if using Insurance Company

I understand that following each Physiotherapy visit I am liable for the appropriate fee

Cancellation Policy

Please help us to help you! By giving 24 hours cancellation notice we can offer your appointment to someone else. Less than 24 hours notice means we will need to charge you for your session if we cannot reallocate it.

Any appointments missed or forgotten will also incur a full charge. If you are unable to speak to a member of the reception staff, please leave a message on the clinic telephone answering machine.

Signed: _____

Privacy Statement

By signing below, you explicitly consent to us processing the personal data you have included on this registration form in accordance with our Privacy Policy which is available for you to read on request

Signed:_____Date:_____

Treatment consent

I consent to the assessment, and treatment being administered by Southwell Physiotherapy and Sports Injury Clinicians (this consent is for 12 months from the date of signature). I understand that the results of any treatment is not guaranteed

Signed:_____Date:_____

The Physiotherapist will be wearing personal protective equipment and garments during the consultation in line with our risk assessment and you will be asked to wear a face covering during the consultation due to the time spent in close contact. You do not have to wear a face covering in the reception of waiting areas. Because of the risk of coronavirus infection, it is important that we make you aware that there is an increased risk of coronavirus infection if you choose to have hands-on treatment, despite all precautions being taken. Please ask your Physiotherapist before signing this form if you have any questions about this information.

I confirm that I have read and understood the content of this consent form, including that there is risk of coronavirus infection in attending a face-to-face consultation. I confirm that I am willing to accept that risk and any consequences thereof. I agree to undertake hands on treatment despite this risk. I confirm that I give consent to the above until I expressly revoke this consent, I have had the opportunity to ask all the questions I wish to, and all of my questions have been answered

Signed:_____Date:_____

Are you a chaperone Yes/No

<u>Communications consent</u>

Southwell Physiotherapy and Sports Injury Clinic may use automated or manual methods for contacting you during your ongoing treatment. You may be contacted for appointments, appointment reminders/changes and treatment plans all of which will be pertinent to current treatment. During your treatment period you will be contacted by one or all of the following: telephone, email and/or SMS. Please tick the box if you agree (required before we are able to continue with treatment)

☐ **I agree Southwell Physiotherapy and Sports Injury Clinic can contact me by any of these methods**

<u>Surveys</u>

As part of Southwell Physiotherapy and Sports Injury Clinics continuing improvements, developments and monitoring, we would like to send you a survey link to be completed by yourselves at the end of your treatment. The completion of this short survey is optional and the link will be sent to you by email or SMS. Please tick the box if you agree.

☐ **I agree Southwell Physiotherapy and Sports Injury sending me the survey link after my treatment is complete by wither of these methods**

<u>Marketing</u>

From time to time, Southwell Physiotherapy and Sports Injury Clinic will introduce new treatment services or offers. We would like to send you information about our own products and services by email and SMS. If you agree to being contacted in this way please check the relevant boxes

☐ **email** ☐**SMS**

Signed:_____Date:_____

Who we are

Southwell Physiotherapy and Sports Injury Clinic is the trading name for Southwell Physiotherapy Limited whose registered office os Longridge, Gravelly Lane, FIskerton, Notts, NG25 0UW. We are a company registered in England and Wales under company number……. We act as the data controller when processing your data. Our designated Data Protection Officer/Appointed person is Carole Sampson who can be contacted at reception@southwellphysio,co.uk

What data we collect

Full name

Full address and/or postcode

Date of birth

Contact telephone number

Email address

Past and current medical history

Current activities of daily living

We collect date provided by you the data subject and occasionally we may contact your GP for additional information with your consent

Why we collect your data

To provide you with allied health professional treatment. We will occasionally send you marketing information where we have assessed that it is beneficial to you as a customer and in our interests. Such information will be non-intrusive and will only be sent on receipt of a double opt in initial contact form.

We may use your data for invoices and billing. We may occasionally use reduced data to perform internal research and statistical analysis regarding our services.

If you were referred to us officially and/or by a third party such as a medico legal company or private health insurance company we may be required to provide summary reports and updates on your progress. We may occasionally be required to hare your data with the Health Care Professions Council (HCPC) to allow them to perform their regulation activities.

☐ **I agree to the data that is collected and being held and used for my treatment or ongoing treatments and billing by Southwell Physiotherapy Limited**

Signed:_____**Date:**_____

HEALTH INSURANCE FORM

Insurance Company Information:

Provider Name: _____

Registration Number: _____

Pre-authorisation Number: _____

Policy excesses – All excesses must be paid by the patient within 7 days of notification by the insurance company or the clinic.
NOTE: If authorisation has NOT been given the patient is liable to pay for treatment until authorisation has been received and given to the clinic.

Health Insurance

It is the patient's responsibility to contact their insurance company for conditions of their policy as we cannot be held responsible for any non-payment of claims or shortfall of treatment fees.

Health insurance **EXCESS AMOUNT** represents the amount of money that the insured party must pay out-of-pocket and up front before the insurance plans kicks in for a specific benefit and begins to cover the cost of physiotherapy.

I agree to my physiotherapist sharing information with my insurance company regarding my treatment.

Signed: _____

MEDICAL HISTORY QUESTIONNAIRE

Listed below are a series of questions which are directly relevant to the treatment of your injury or illness. **Please circle** the appropriate answer to each question. Your physiotherapist will discuss any queries you may have.

To the best of your knowledge, have you had or presently suffer with any of the following:

1. Heart problems i.e. (myocardial infarction) Yes/No
2. Jaundice Yes/No
3. Tuberculosis Yes/No
4. Hypertension (high BP) Yes/No
5. Rheumatoid Arthritis Yes/No
6. Epilepsy Yes/No
7. Asthma Yes/No
8. Diabetes Mellitus Yes/No
9. Stroke Yes/No
10. Do you have a pacemaker Yes/No
11. Are you pregnant Yes/No
12. Do you take anticoagulants Yes/No
13. Do you take steroids Yes/No
14. Dizziness Yes/No
15. Anaemia Yes/No
16. Osteoporosis Yes/No
17. Balance problems Yes/No
18. Recent weight loss Yes/No
19. Previous history of cancer Yes/No
20. Bowel or bladder problems Yes/No
21. Have you had any X-rays or other investigations for your current problem Yes/No
22. General joint stiffness Yes/No

If you answered YES to any of the above questions, please give more details in the space below and discuss with your physiotherapist

It is important to your treatment and care that we also have a FULL list of your CURRENT medication

The above information is given to the best of my knowledge.

Name: ……

Signature: ……

Date: ……

Please use the other side of this sheet if necessary