



Patient Registration Form

Title: _____ Patient Name: _____
DOB: _____
Address: _____
Tel No. Home: _____ Mobile: _____
Email: _____
Occupation: _____
Referral Source: _____

Consent

I consent to the assessment and treatment recommended and performed by Jon Cooke Physiotherapy in accordance with the governing body's professional guidelines. This may include mobilisation, manipulation, manual therapy techniques, soft tissue massage, acupuncture, or electrotherapy modalities. I understand that before any treatment is carried out, a full explanation of the purpose and any risks of that treatment will be provided. I understand that should I wish to decline any form of assessment of treatment, then I am entirely within my right to do so and that I should inform the clinician of my wishes at the time. By signing overleaf I am in agreement with these conditions.

Informing Your GP

It is good practice to keep your GP informed of all aspects relating to your health. Please complete the following information if you are happy for us to contact your GP.

I agree [] I would prefer to receive any information personally []

GP Name: _____

Address: _____

Chaperone

We do offer a chaperone service. If you would like a chaperone please tick here []

Medical Conditions

Do you have any medical conditions the clinician is required to know about, such as, Diabetes, Epilepsy, Heart Conditions, High Blood Pressure, Pace Maker, Metal Implant?

Please tick here [] and note the conditions below.

Payment Details

Is your treatment to be covered by medical insurance? Yes [] No []

Insurance Company Name:

Membership Number:

Authorisation Number or Group Name/No:

Making Payment Today

If you do not have medical insurance, please indicate how you will be paying your fees today:

Cash [] Cheque []

Third Party

If your examination fees are to be met by a third party (e.g. Solicitors) please complete the details below:

Name of Third Party: _____ Reference Number: _____

Contact Details: _____

Important Note I understand and accept that it is my responsibility to ensure prompt settlement of any fees and not that of a medical insurance company or third party and if, for whatever reason, my medical insurance company or third party do not pay my fees within 30 days I will be asked to pay Jon Cooke Physiotherapy directly. By signing below you are agreeing to these conditions.

Cancellation Policy Clients who book appointments at Jon Cooke Physiotherapy are required to give 24 hours advanced notice of their inability to attend, otherwise they will be charged in full for the appointment they fail to attend. This policy is deemed necessary to avoid denying appointments to patients who may be on the waiting list.

Data Protection All information collecting during the course of your assessment and treatment at Jon Cooke Physiotherapy will remain strictly confidential under the terms of the Data Protection Act.

Name: _____

Signature: _____

Patient [] Parent [] Guardian []

Date: _____