iGoPhysio

Patient Registration Form

Title / First name	Surname	Date Of Birth

Address		
Tel (H)	Tel (w)	
Tel (M)		
Email Address		
GP Name/Address		
Contact Person In Case Of Emergency	Tel	

Current Medical History

Have you had any surgery?	
Have you had any fractures?	
Do you have any metal (pins/plates/screws) in place?	
Are you or could you be pregnant?	

Have you previously or are you currently suffering from any of the following:

Cardiac/Heart Conditions	Yes/No	Diabetes	Yes/No	High/Low Blood Pressure	Yes/No
Epilepsy	Yes/No	Rheumatoid Arthritis	Yes/No	Pacemaker	Yes/No
Unexplained Weight Loss	Yes/No	Skin Conditions	Yes/No	Osteoporosis or Other brittle bone disease	Yes/No
Neurological Disorder e.g. stroke, MS	Yes/No	Psychiatric Illness	Yes/No	Asthma/Breathing Problems	Yes/No
Cancer	Yes/No	Bowel / Bladder Dysfunction	Yes/No	Digestive Problems	Yes/No

If you answered "yes" to any of the above please provide further detail:

Medication (Are you on any medication (including Hormone Replacement Therapy, Steroids and anti-coagulants)? Past and Present.

Any Other Information?

Patient Signature/Guardian (if under 16 years of age)	Date

p.t.o.

iGoPhysio

Terms and Conditions Of Practice

1. You must inform us immediately of any change in your medical condition, as it may affect your treatment.

2. Must not interfere or adjust any equipment used during your treatment.

3. Must follow the advice and instructions provided at all times.

4. Accept that neither Golders Hill Medical Practice or the therapist accept any liability whatsoever for any injury or death unless it is caused directly by negligence on one of the therapists.

5. Understand that my GP, Specialist or Consultant may be informed of any attendance and progress, unless I specify otherwise.

6. **Payment Of Fees**:
   a. I understand that irrespective of whether I have medical insurance or a third party claim I am solely liable for the professional fees and agree to settle these bills.
   b. Method Of Payment:

      i. Directly After Every Treatment Session by Cheque, Cash or Credit / Debit card.

      ii. Through a medical insurance scheme.

      Insurance Company name ______________________________

      Policy No ______________________________

      Authorisation No ______________________________

      Limit Of Cover ______________________________

      We will only deal with your insurance company if ALL the above information is provided and current. If payment is not received within 4 weeks of invoice we will require payment from you directly, and provide a insurance valid invoice for you to seek reimbursement.

   c. I understand that the practice operates a strict 24-hour cancellation and rescheduling policy and agree that I will be charged unless I provide adequate notice.

   d. I have read and understood these terms and conditions and agree to abide by them.

I declare that I have filled out my questionnaire comprehensively, truthfully and to the best of my ability.

Patient Signature/Guardian (if under 16 years of age)	Date