Payment Form

Title: _____ **First Name:** _____

Last Name: _____

What is your gender?

◯ Male ◯ Female

Date of Birth: _____ dd / mm / yyyy

Marital Status

◯ Married ◯ Single ◯ Divorced ◯ Widowed

Mobile Phone Number: _____ **Email address:** _____

Occupation: _____

Do you have any allergies?

◯ Yes ◯ No

If yes, write your allergy: _____

Are you taking any medicines, drugs and pills?

◯ No ◯ Yes

If you answered YES to the above please give details.

GP/Surgery name

Medical notes at: (if held elsewhere to GP)

GP/Surgery Address

Emergency contact name: _____ **Emergency contact number:** _____

All fields are required to be filled below. If any of the below do not apply to you please type N/A

Payment method/ Insurance company

- ◯ Self pay
- ◯ Axa PPP
- ◯ Bupa
- ◯ Cigna
- ◯ Aviva
- ◯ WPA
- ◯ Aetna International
- ◯ Bupa International
- ◯ Axa International
- ◯ Cigna International
- ◯ Vitality
- ◯ Allianz
- ◯ Simply Health

Insurance Membership/Policy number.: _____ **Insurance Authorisation code:** _____

Additional Insurance details (e.g policy excess, no of sessions, policy limit etc.)

Please read our Terms of Payment: (Please note Health insurance can only be used for services that we have confirmed we are contracted to process on your behalf- please ask if you are unsure.) For Self-Payers, we request that payment is made on the day at the conclusion of your consultation at reception. For those with Insurance Cover, please be advised that we require a Membership number and a Pre-authorisation Code in order for us to invoice your Insurance Company directly. Without these, we request that payment is made on the day, and we will supply you with a receipt for you to claim back from your insurance. Should any cover be declined OR details rejected, this is your responsibility to settle with us. By signing below, you are stating your understanding and agreement to our Payment Terms and Conditions.

Signature

Date: _____ dd / mm / yyyy