

THE COURTFIELD MEDICAL PRACTICE
PRIVATE PATIENT REGISTRATION FORM

TITLE _____ **FORENAMES** _____

SURNAME _____

ADDRESS

TELEPHONE NUMBER (HOME)

TELEPHONE NUMBER (WORK)

DATE OF BIRTH: _____

TELEPHONE NUMBER (MOBILE)

NOTES

HOW DID YOU HEAR OF US (WEBSITE, PATIENT RECOMMENDATION ETC.)

STATEMENT

I have read the practice brochure and current price list, which details the charges for each service that the Courtfield Medical Practice is able to provide.

In particular, I agree to the current charges for surgery consultations, telephone consultations, telephone or fax prescriptions, home visits and health screens. I also understand that these charges are reviewed on the 1st January every year.

I agree to settle any payments due to the Courtfield Medical Practice at the time of the consultation, and understand that failure to do so will result in an additional £5.00 administration charge being added to my account. This applies to either myself or to my family.

Signed:

Date:

Please note that in the event of a home visit being necessary, doctors from the Courtfield Medical Practice will endeavour to carry this out. However, at weekends and evenings, this may be carried out by an independent doctor service – currently Night Doctor. This service is chargeable.