REGISTRATION FORM

TITLE ………………. **FORENAMES** …………………………………………….

SURNAME ……………………………………………………………………………………………………….

ADDRESS ……………………………………………………………………………………………………….

……………………………………………………………………………………………………….

HOME TEL ……………………………………………. **WORK TEL** ………………………………………

MOBILE ……………………………………………. **EMAIL** ……………………………………

DATE OF BIRTH ………………………………

SCHOOL DETAILS ……………………………………………………………………………………………

……………………………………………………………………………………………

NOTES ……………………………………………………………………………………………………

……………………………………………………………………………………………………

HOW DID YOU HEAR OF US? (Website, patient recommendations etc.)

……………………………………………………………………………………………………

STATEMENT:

I have read the Practice brochure and current price list, which details the charges for each service that Courtfield Private Practice is able to provide. In particular, I agree to the current charges for the surgery consultations, telephone consultations, telephone or fax prescriptions, home visits and health screens. I also understand that these charges are revised on the 1st January of every year.

I agree to settle any payments due to Courtfield Private Practice at the time of the consultation and not through an insurance company. **Appointments cancelled on the day of the appointment will incur a charge of 50% of the consultation fee. Failure to attend your appointment will also incur a charge.**

SIGNED **DATE**

Please note: In the event of a home visit being necessary, doctors from Courtfield Private Practice will endeavour to carry this out. However, at weekends and evenings this may be carried out by an independent doctor service. This service is chargeable.