THE
LONDON SKIN AND HAIR
CLINIC

The London Skin and Hair Clinic New Patient Registration and Agreement

Title: _____ **First Name**: _____ **Middle initial** __ **Last name**: _____

Sex: ☐ Male ☐ Female ☐ Intersex **Date of Birth:** ___ / ___ / _____
DD / MM / YYYY

Correspondence Address
First line: _____

Second line: _____ _____ Mobile phone _____

Third line: _____ Home phone (___) _____

Town: _____ Work phone (___) _____

County: _____

Postcode: _____ Email: _____

Country: _____ Alternative email: _____

Next of Kin or Guardian: Title: _____ **First Name**: _____ **Last name**: _____

Relationship _____ **Contact Number:** _____

Address: _____

For Children under 14 years of age

Name and address of School: _____

UK GP or UK Referring Specialist which medical correspondence will be sent to	**Additional UK GP or UK Specialist to be copied in on medical correspondence**
Name: _____	Name: _____
Practice: _____	Practice: _____
Address: _____	Address: _____
_____ Postcode: _____	_____ Postcode: _____

Communications Preferences
☐ Tick box if you **do not want** to be notified about news and offers from The London Skin and Hair Clinic

How did you find out about The London Skin and Hair Clinic?
☐ Referring Doctor ☐ Another patient ☐ Medical insurer ☐ Web-search Google
☐ Web other: _____ ☐ Press: _____ ☐ Other – specify _____

I understand that as a private clinic, not associated with the NHS, all appointments, services rendered and items supplied will be charged to the patient.

Payment Method

☐ Self-pay ☐ Private health insurance
Complete following page

☐ Embassy / sponsored
Letter of guarantee required each appointment

Signature: _____ **Todays Date:** ___ / ___ / _____
DD / MM / YYYY

Name (if Guardian or Parent signing for under 16 year old): _____

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The London Skin and Hair Clinic Medical Insurer and Third Party Payments

Medical Insurance Details

Tick	Name of insurer	Membership number	Group / Company	Authorisation / Claim reference
	Aetna International	**W** _ _ _ _ _ _ _ _ _		*not applicable*
	Allianz Worldwide Care	**P** _ _ _ _ _ _ _ _ _	*not applicable*	**P** _ _ _ _ _ _ _
	Aviva	_ _ _ _ _ _	*not applicable*	_ _ _ _ _ _ **** _ _
	AXAPPP	_ _ _ _ _ _ _ _	*not applicable*	_ _ _ _ _ _ _
	AXAPPP International	**INTL** _ _ _ _ _ _ _	*not applicable*	_ _ _ _ _ _ _
	Blue Cross Blue Shield Global	_ _ _ _ _ _ _ _ _ _ _ _ _		*not applicable*
	BUPA UK	_ _ _ _ _ _ _ _ _ _	*not applicable*	_ _ _ _ _ _ _
	BUPA Global International	**BI -**____**-** ____**-**____		**A** _ _ _ _ _ _ _
	Cigna UK	_ _ _ _ _ _ _ _ _	*not applicable*	_ _ _ _ _ _ _ _ _
	Cigna International	_ _ _ _ _ _ _ _ _ _ _		*not applicable*
	Exeter Family Friendly	_ _ _ _ _ _ _ _ **PP**_ _	*not applicable*	_ _ _ _ _ _ _ **/** _
	GeoBlue International	**H** _ _ _ _ _ _ _ _ _	*not applicable*	**ENG** _ _ _ _ _ _ _
	Healix	_ _ _ _ _ _ _ _ _ _	*not applicable*	_ _ _ _ _ _ **A**
	Henner (GMC)		*not applicable*	**[Photocopy card]**
	HTH Worldwide	**H** _ _ _ _ _ _ _ _ _	*not applicable*	**ENG** _ _ _ _ _ _ _
	Simply Health	**STP**_ _ _ _ _ _	*not applicable*	**STP**_ _ _ _ _ _
	UnitedHealthcare International	**A** _ _ _ _ _ _ _ _ _		*not applicable*
	Vitality Pruhealth	_ _ _ _ _ _ _ _ _ _	*not applicable*	_ _ _ _ _ _ _ _ _
	WPA	_ _ _ _ _ _ _ _ _	*not applicable*	_ _ _ _ _ _

PAYMENT UNDERTAKING All patients / patient payor / representative

1. I/the patient give permission for the clinic to provide diagnosis information and copies of my GP referral and / or medical report to my medical insurer/third party sponsor in order for them to assess and process the clinic charges.
2. I/the patient understand that the clinic is not able to bill medical insurers/third party sponsors for laser treatment, aesthetic and cosmetic treatments, products including prescription items, repeat prescription fees, late fees, digital photography fees and I/the patient agrees to pay for these items in full on the day of treatment.
3. I/the patient understand that BUPA does not cover digital photography (including stereotactic device) used in hair-loss and scalp appointments and I will be liable for this charge (£20 fee)
4. In consideration of the clinic accepting me/the patient for medical care, I/we undertake to pay all services rendered and items supplied to me/the patient in accordance with the clinic's charges applicable at the time of treatment. I acknowledge that I remain liable for such payment, whether or not I/ the patient have/has medical insurance/third party sponsorship in respect of some or all of the services provided and items supplied. If following billing of my medical insurer/third party sponsor there is a shortfall, co-payment or excess or if the medical insurer/third party declines covering the charges in part or in full, I accept that I/the patient will be invoiced for this sum and I/the patient hereby agree to pay in full within 30 days of invoicing.

Signature: _____ **Todays Date:** ___ / ___ / _____
DD / MM / YYYY

Name (if Guardian or Parent signing for under 16 year old): _____

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The London Skin and Hair Clinic Confidential Medical Questionnaire – All patients

Title: _____ **First Names**: _____ **Last name**: _____

Sex: ☐ Male / ☐ Female **Date of Birth:** ___ / ___ / ___
dd / mm / yy

Occupation:_____

1. Which **ethnic group** best describes your background? (you are not obliged to complete this section)

☐ Arab ☐ Bangladeshi ☐ Black-African ☐ Black-Caribbean
☐ Chinese ☐ Indian ☐ Pakistani ☐ White
☐ Other: specify _____

2. **Country of Birth**: _____

3. **Medical History**: Please tick any boxes that apply now or in the past:

☐ Anaemia ☐ Asthma ☐ Blood disorders
☐ Depression ☐ Diabetes ☐ Eczema/Dermatitis/Psoriasis
☐ Gut or bowel disease ☐ Keloid scars / Poor wound heal
☐ Cancer: please specify -

4. Are you currently taking any **medications** (prescribed, over the counter, herbal, Chinese)? ☐ Yes ☐ No

If yes, please specify name of medication, dose and frequency: _____

_____

_____

_____

5. Do you have any allergies? ☐ Yes ☐ No If yes, please specify: _____

_____

6. (For women) Are you **pregnant** or do you think you may be pregnant? ☐ Yes ☐ No

7 Do you need **antibiotics** before dental work? ☐ Yes ☐ No

8. Do you take **blood thinners** (e.g. aspirin)? ☐ Yes ☐ No

9. Have you ever had a reaction to a local or general anaesthetic? ☐ Yes ☐ No

10. Do you bruise easily or bleed excessively? ☐ Yes ☐ No

11. Do you carry a warning card? ☐ Yes ☐ No
If yes, what for: _____

12. **Family History**: Please list any conditions that you have a family history of in your immediate family (parents, grandparents, siblings): _____

_____

_____

13. **Life Style** (for patients over 16):

Smoking ☐ **Yes** / ☐ **No** If yes, cigarettes/week _____

Alcohol ☐ **Yes** / ☐ **No** If yes, units/week _____

Please note that all details provided will be handled and stored in accordance with the Data Protection Act 1998. It is essential that you complete this form accurately. Failure to do so may result in incorrect treatment and compromise your safety for which The London Skin and Hair Clinic will not be responsible.

Signature: _____ Date: ___ / ___ / ___
dd / mm / yy

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The London Skin and Hair Clinic Confidential Medical Questionnaire – For Hair and Scalp conditions

1. **Date Hair loss or scalp condition commenced:** ___ / ___ / ___
dd / mm / yy

2. **Description of hair loss or scalp condition**: Please tick all boxes that apply:

Areas affected:	*Type of hair loss:*	*Pattern of hair loss:*	*Symptoms and signs:*
☐ Top of scalp	☐ Hair thinning	☐ Diffuse loss	☐ Itchy
☐ Sides of scalp	☐ Hair shedding	☐ Patchy loss	☐ Painful
☐ Back of scalp	☐ Hair breaking		☐ Sensitive
☐ All over scalp			☐ Pustules
☐ Beard			☐ Scaling
☐ Elsewhere (specify):			

3. Please provide any further details about the **type of hair loss or scalp condition** experienced:

_____

_____

_____

4. Have you had previous similar episodes in the past? ☐ **Yes** ☐ **No**
If yes detail when, what happened, and the outcome: _____

_____

_____

_____

5. Did you **start or stop medication** up to 6-12 months prior to hair loss or scalp condition?
☐ **Started** ☐ **Stopped** ☐ **No**
If started or stopped, please specify: _____

_____

_____

_____

6. Was there any **unusual events, illnesses, stresses or life changes** three (3) to six (6) months before the hair loss or scalp condition commenced (e.g. personal, work, health, family)? ☐ Yes ☐ No
If yes, please specify:_____

_____

_____

_____

7. Please describe your diet (tick all boxes that apply) ☐ **I eat red meat (beef / lamb)** ☐ **I am a vegetarian**
☐ **I am a vegan** ☐ **I have had dramatic weight loss** ☐ **I have had dramatic weight gain**
☐ **I am on a special diet.** Please specify: _____

8**. Family history** of hair loss. Have any of your immediate family experienced hair loss (please tick boxes and provide comments for all that apply)

Has experienced hair loss	*Extent and type of hair loss*
☐ Mother	
☐ Father	
☐ Brother(s)	
☐ Sister(s)	
☐ Grandparents	
☐ Aunt(s)	
☐ Uncle(s)	

9. **Hair styling and care**: Please tick all boxes that apply currently or in the past:

Hair drying:
☐ Air dry
☐ Hair dryer
☐ Hair curling wand
☐ Hair straightening
☐ Towel dry

Hair styling:
☐ Perm
☐ Colour
☐ Braiding / plaits
☐ Dreadlocks
☐ Extensions
☐ Wig / toupee

10. Please list all the **hair care products** you currently use or have used regularly in the past:

Shampoo / Conditioner	Leave in hair product	Hair colouring product (permanent or temporary)	Hair gel, wax or other controlling product	Hair loss or regrowth product

11. Have you had any **tests done** to date (e.g. blood tests or biopsy)? ☐ **Yes** ☐ **No**

If yes, please specify: _____

_____

_____

12. Please list any medical or non-medical practitioners you have consulted in relation to your hair loss:

Date (mm/yy)	Practitioner / Centre	Type of practitioner	Advice given	Outcome

13. Please describe treatment to date and response: _____

_____

_____

_____

_____

14. Please describe prescriptions to date (including herbal and Chinese): _____

_____

_____

_____

_____

15. Please provide any further details on how you are managing the hair loss that you feel is relevant: _____

_____

_____

_____

For female patients

16. Is your menstrual cycle regular? ☐ **Yes** ☐ **No**

17. Did you experience hair loss during or after pregnancy? ☐ **Yes** ☐ **No**

18. Have you been told you have Polycystic Ovarian Syndrome (PCOS)? ☐ **Yes** ☐ **No**

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The London Skin and Hair Clinic Patient Agreement

Patient Responsibility

When you are a patient of The London Skin and Hair Clinic it is your responsibility to:

1. Provide accurate and complete information about your past illnesses, hospitalisations, medications and other matters relating to your health and mental health
2. Tell your Doctor if you do not understand your treatment or what you are expected to do
3. Tell your Doctor if there is a change in your condition or if problems arise during your treatment
4. Follow the treatment plan recommended by your Doctor
5. Be courteous and considerate of other patients and of Clinic staff. Patients are expected to assist in maintaining a quiet environment and being respectful of clinic property
6. Arrive at least fifteen minutes before your appointment time to ensure that you are not late and subsequently impact the appointments of our other patients. If you are late for your appointment we can not guarantee that the Doctor will be able to see you and it may be necessary to book a new appointment
7. Provide us with at least 24 hours notice in the event you need to cancel or make a change to your appointment time. The clinic reserves the right to charge 50% of the appointment and treatment fee where 24 hours notice is not given to cancel or change appointment times.
8. Provide accurate information relating to insurance or other sources of payment.
9. Comply with the requests by your Doctor for review appointments within the time period specified

Where treatment advice and prescribed therapy has not been adhered to, and requests for follow-up have not been actioned by the patient, continuity of care will have been deemed not to have been given and therefore no responsibility will be taken by The London Skin and Hair Clinic.

Financial Policy

1. As a private clinic, not associated with the NHS, all appointments, services rendered and items supplied will be charged to the patient.
2. The London Skin and Hair Clinic is happy to provide a written quotation for all procedures which is valid for 3 months. A full skin examination and medical history is required before a safe treatment plan can be decided upon and for this reason we will not issue a quotation until the patient has been examined by one of our Doctors
3. Our payment terms are payment in full on the day.
4. Patients with medical insurance/third party sponsorship in respect of some or all of the services provided and items supplied are responsible for ensuring that they will be fully covered and in the event that their medical insurer/third party sponsor subsequently declines covering the charges in part or in full they accept that they will be invoiced for this sum and payment will be required within 30 days of invoicing.
5. We reserve the right to charge interest on late payment of invoices and collection charges should we require the services of a debt collection company or should we need to apply to the County Court to recover amounts owing.
6. Where an invoice is outstanding for greater than 60 days we reserve the right to use the services of a debt collection company, to provide them with the information required in order to perform their service, and we reserve the right to discharge the patient from the care of the clinic.

Patient Data Protection and Confidentiality

1. The London Skin and Hair Clinic will handle and store patient information, including clinical photographs, in accordance with the Data Protection Act 1998 and the General Medical Council disclosure guidelines. Information is protected at all times against improper disclosure, staff are trained and understand their responsibilities and patient administrative information can be accessed separately from clinical information.
2. I understand that unless I object, my identifiable personal information may be disclosed for the sake of my own care with the healthcare team, for local clinical audit, to any person or organisation who may be responsible for meeting my treatment expenses, or their agents, and if required by a Court of law. Where identifiable information is required for other purposes I understand that The London Skin and Hair clinic will seek my consent prior to disclosure.