



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: _____
Third line: _____
Town: _____
County: _____
Postcode: _____
Country: _____

Mobile phone _____
Home phone (____) _____
Work phone (____) _____

Email: _____
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: _____

<p>UK GP or UK Referring Specialist which medical correspondence will be sent to</p> <p>Name: _____</p> <p>Practice: _____</p> <p>Address: _____</p> <p>_____ Postcode: _____</p>
--

<p>Additional UK GP or UK Specialist to be copied in on medical correspondence</p> <p>Name: _____</p> <p>Practice: _____</p> <p>Address: _____</p> <p>_____ Postcode: _____</p>
--

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 Embassy / sponsored
Complete following page Letter of guarantee required each appointment

Signature: _____ **Today's Date:** ___ / ___ / ___
DD / MM / YYYY

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



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 _____		<i>not applicable</i>
	Allianz Worldwide Care	P _____	<i>not applicable</i>	P _____
	Aviva	_____	<i>not applicable</i>	_____ \ _____
	AXAPPP	_____	<i>not applicable</i>	_____
	AXAPPP International	INTL _____	<i>not applicable</i>	_____
	Blue Cross Blue Shield Global	_____		<i>not applicable</i>
	BUPA UK	_____	<i>not applicable</i>	_____
	BUPA Global International	BI - ____ - ____ - ____		A _____
	Cigna UK	_____	<i>not applicable</i>	_____
	Cigna International	_____		<i>not applicable</i>
	Exeter Family Friendly	_____ PP ____	<i>not applicable</i>	_____ / _____
	GeoBlue International	H _____	<i>not applicable</i>	ENG _____
	Healix	_____	<i>not applicable</i>	_____ A
	Henner (GMC)		<i>not applicable</i>	[Photocopy card]
	HTH Worldwide	H _____	<i>not applicable</i>	ENG _____
	Simply Health	STP _____	<i>not applicable</i>	STP _____
	UnitedHealthcare International	A _____		<i>not applicable</i>
	Vitality Pruhealth	_____	<i>not applicable</i>	_____
	WPA	_____	<i>not applicable</i>	_____

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: _____ **Today's Date:** ____ / ____ / ____
 DD / MM / YYYY

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



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



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.