EYE HEALTH CARE – SIMON HORGAN LTD
OUTPATIENT REGISTRATION FORM

Please complete the registration form by printing in block capitals. Where the patient is 17 or less, their parent or guardian should complete the form. Please ensure to read and sign the declaration and consent at the bottom of the page.

Patient's Personal Details

Title_____ Surname _____

First Name(s) _____

Date of Bi_____

Add_____

_____

_____Postcod_____

Parent/guardian (if patient u_____

_____

Telephone (m) _____

Telephone (h) _____

Telephone (w) _____

Email _____

Occupation _____

Referring GP or Optometrist Details

Name _____

Address _____

_____

_____

Telephone _____

_____

Insurance Details
(please complete a new registration form at any time there is a change to billing)

Self Pa_____ YES/NO
How w_____ you like to settle your account?
Plea_____ indi_____te: **Debit/Credit** card or **Bank T_____nsfer**
Insura_____ Co _____

P_____licy No _____

Pre-Authorisati_____n No_____

Please note: If you do not sup_____ the correct membership numbe_____ & pre-authori_____ation number, we will be unable to submit o_____ invo_____e to t_____e ins_____rer and you will be liable for the f_____e.

Declaration and consent:

I confirm specialist treatment has been recommended and that to the best of my kn_____wled_____e _____d belief, the information I have given on this form is true and correct. Where required to assess my cla_____n, I consent to my insurer obtaining a medical report from my specialist as to the history and nature of the condit_____ or its treatment. I authorise my Consultant and the facility where I am seen, to submit my claim and accounts dire_____y to my insurer on my behalf. In the absence of a preauthorisation number, I understand I may be required to settle the account at the time of treatment from both the Consultant and the clinic/hospital. Fees have been provided to me.

PLEASE CONTINUE OVER THE PAGE TO READ OUR PRIVACY STATEMENT AND SIGN

EYE HEALTH CARE - PRIVACY STATEMENT

Declaration and consent

By signing this form, I authorise Eye Health Care to use information about me as provided by me and to submit their invoices directly to me or my insurer. If my insurance is based outside the UK, I accept that I will be responsible for payment. If an invoice is not met by my insurer, I undertake to settle these accounts promptly on receipt of an invoice.

Consent for collecting, storing and processing personal information

In order to provide you with the best care possible, Eye Health Care needs to record and store information about you. We will keep a record of contact details, next of kin and clinical information.

Your data will be used to:

- provide health care
- complete insurance claims and invoices
- Report activity to regulatory organisations.

Your data will be shared with:

- Your consultant and other healthcare specialists involved in your care including your GP.
- Primary Medical Insurance and debt collection agencies if necessary.
- Regulatory organisations
- DGL Practice Manager, operated by the Clan William Group, for compilation of correspondence and invoicing, whose privacy agreement Eye Health Care has signed

Eye Health Care stores data according to the NHS Records Management Code of Practice for Health and Social Care 2016 which ensures the maximum level of security and accuracy of your data.

You have the following rights regarding your data:

- The right to be informed about what data is stored
- The right to access the data
- The right to rectification of data
- The right to erasure of the data
- The right to restrict processing of the data
- The right to data portability
- The right to object to us storing your data

If you have any concerns about Eye Health Care storing and processing your data, please contact the Practice Manager on 020 7060 9911.

Please sign below that you consent to Eye Health Care storing your information.

DECLARATION AND CONSENT

Please read the details above and the statements below which relate to communicating about your treatment and sign that you agree below:

I agree to Eye Health Care's terms and conditions

I consent to Eye Health Care storing and processing my personal data

I have received information regarding fees[consultations/treatment]

[fees letters are emailed prior to the appointment and are available on the website www.eyehealthcare.co.uk]

I am happy to be contacted by telephone

I am happy to be contacted by email and my email address and contact telephone numbers are correct (encrypted email will be used to send your clinic letter & any invoice payable – you will need to enter your DOB in 6 digit format to access the document/s)

If you are self funding, how would you like to settle your account?

Please indicate: **Debit/Credit Card** or **Bank transfer**

Signed……Dated ……

Name (printed) …….. (patient or parent/guardian)

Would you like a copy of this form scanned and emailed to you? Y / N