

Dr Ravi Suchak
Consultant Dermatologist & Dermatopathologist

PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

Title

Name

Date of birth:

Address.....

..... Postcode

Contact Tel No's - Home

Mobile

Please indicate how you prefer to be contacted (tick all that apply) –

- ☐ Letter
- ☐ Phone
- ☐ SMS Text
- ☐ Email** - Provide address

(To legally comply with GDPR regulations emails with patient identifiable information will only be sent encrypted through Egress Switch. Free patient registration will be required to use this service. If you do not wish to receive emails in this way all correspondence will be sent via Royal Mail.)**

GP

GP Address

Insured / Self-funding (please delete which does not apply)

Insurance Company

Policy No** Authorisation No

(Invoices are sent electronically. Failure to provide full and correct insurance details may result in any invoice being sent to you for settlement)**

Please read and sign the Terms of Business overleaf

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TERMS OF BUSINESS

You are seeking private medical treatment and are liable for the costs incurred.

If you have private medical insurance it is your responsibility to check that your insurance will cover the costs – please check as you will be liable for any costs that your insurance does not cover or if there is an excess on your policy. You will be sent an invoice in the post for any shortfall/excess – please read our **Terms and Conditions of Payment** below.

Prices for Consultations/procedures/operations are within limits set by major insurance companies.

The “fee” for procedures/operations is for performing the procedure/operation and does not include hospital charges, which will be separately charged by the hospital.

Where you are invoiced for the treatment you receive it is your responsibility to forward this to your insurance company if you have one.

If you are self-funding all invoices will be sent to you in the post – please read our **Terms and Conditions of Payment** below.

TERMS AND CONDITIONS OF PAYMENT

In the absence of prior written agreement to the contrary, payment of our charges is required on receipt of our invoice. Failure to make payment within 28-days of the due date may result in the matter being referred to P&J CDS our debt collection agents, whose charges will be added to and payable with the invoice debt.

As your treating clinician and therefore custodian of personal information relating to your medical treatment I must only use that information in accordance with all applicable law and guidance. A detailed privacy notice is available online at –
www.essex-dermatology.co.uk

DECLARATION AND CONSENT

I confirm that to the best of my knowledge the information I have given on this form is correct. Where this is required to assess my claim, I consent to my insurer obtaining a medical report from Dr Suchak as to the history and nature of the condition or its' treatment. I consent to any medical information and photographs taken to be stored in my medical records and also digitally. I consent to receiving future reminders for investigations or procedures appropriate to my condition. If I am making my claims against my health insurance company and they are not met by an insurer or third party I undertake to settle the accounts promptly on receipt of an invoice. I understand 24-hours' notice is required for cancellation of appointments otherwise a late cancellation/non-attendance invoice will be issued.

If there is anything you do not understand or agree with please ask before treatment commences. A copy of this agreement is available on request.

Signed

Date

Please print name