

TERMS FOR PRIVATE TREATMENT, CONSENT & FINANCIAL AGREEMENT (Outpatient, Day Patients and Wellbeing Centres)

1. PERSONAL DETAILS

Title (Mr, Mrs, Miss):			
Full Name:			
Date of Birth:			
Full Address:			
	May we send you post regarding: Appointments: Yes <input type="checkbox"/> No <input type="checkbox"/> Progress reports: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Contact Details			
Home:	Number:		
	Are we able to leave a discreet message on this number?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mobile:	Number:		
	Are we able to leave a discreet message on this number?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Do you accept text messages from time to time regarding appointments?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Work:	Number:		
	Are we able to leave a discreet message on this number?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Email:	Email:		
	Are we able to email you information or updates about your appointments and/or progress reports?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
GP Name:			
GP Surgery Address:			
GP Phone Number:			
Next of Kin Name:			
Relationship to Patient:			
Next of Kin Address:			
Next of Kin Contact Number:			

2. CONSENT – You must complete all sections

Treatment – Your doctor/therapist will explain to you the nature and purpose of the treatment they propose and the benefits and side effects that you might experience. Your doctor/therapist may recommend changes to this plan as your treatment progresses and will always keep you informed of the intentions and side effects of any new or changed treatment.

Information Sharing - During the course of your treatment at the Priory Service we want to make sure that we fulfil all your expectations for confidentiality. We take confidentiality and data protection extremely seriously and we will always keep your information securely and only use it for the purposes of your treatment at the Priory Well Being Centre. During your treatment, we may need to share information about you with other people. We would therefore like to know who we are able to contact with information about you. For young people under 18 years of age, we will always share information with your GP as standard; therefore exception of communication with GP below does not apply to you

Do you give permission for clinical information to be shared with your GP?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Would you like progress reports to be sent to your GP?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Would you like progress reports to be sent to you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Your GP will not be contacted without your prior agreement, unless it is for a reason of risk.

Who can the Priory contact in an emergency? Please state clearly the person’s name, contact telephone number and their relationship to you.

I **consent** to the following relatives/friends/professionals being given information about my treatment. Please state clearly relationship of the persons named to you. If none, please state 'none'.

I understand that a multi-disciplinary team of health professionals at Priory may be involved in my care, who will share relevant information about my condition and treatment.

I understand that, as I will be attending Priory Group premises for consultations and treatment, my non-clinical details (name, age, address, and date of birth) will be recorded on your database for administrative and accounting purposes. I have been given a copy of LE Form: 04 to explain how you keep my data secure.

I understand that Priory Group shall bear no liability to me or any third party for any information, progress reports or invoices/receipts sent to an address which I have given them which, for whatever reason, is incorrect.

I also understand that clinical details and treatment progress reports may be shared with my Private Medical Insurer or Treatment Funder to secure treatment funding. I accept that if my referral is managed by the Priory Corporate Clients team, clinical details and treatment progress reports may be shared by them with my treatment funder or Private Medical Insurance.

I give permission for clinical documentation and the opinion survey to be used for purposes of clinical/quality audit and I understand that this is carried out anonymously; it may be used by insurance companies and healthcare regulators as part of their regular audit of Priory’s care.

Healthcare

(Person with parental responsibility to sign if patient under the age of 18, or patient if assessed to be Gillick competent)

Signature	
Name in BLOCK CAPITALS	
Date	
Name of patient if under 18	

3. PAYMENT

Funding must be in place prior to commencement of your treatment. Regardless of your funding method, credit card details must be provided prior to the commencement of treatment as a form of guarantee. Please provide this information by completing the Credit Care Guarantee Form and returning it to either your therapist or the Reception Team.

Please complete the relevant funding section.

Self-Funding – If you are paying for treatment yourself, credit/debit card payments are accepted. Payment for sessions will be due prior to the commencement of each session. An automated payment system is also available should you wish for your card to be debited automatically each time you attend for treatment. Please ask for information or refer to the Credit Card Guarantee form for further details.

NB: Please note that we also accept cash or cheques.

If you would like 'Automated Payment' to be set up for you, please tick this box.

Private Medical Insurance – If your treatment is funded by private medical insurance (PMI) please complete the following details to enable us to invoice your Private Medical Insurer directly:

Insurance Company Details

Name of Insurer:	
Name of Policy Holder:	
Policy/Membership Number:	
Registration/Group Number:	
Authorisation Number:	
Excess Payment Value:	£

You are responsible for ensuring your treatment is pre-authorized by your Insurer and that your Insurer will cover the agreed type and number of treatment sessions. You shall be liable for all costs associated with treatment that have not been authorised by your Insurer (or which fall outside of the scope of your policy), including taking more than the authorised number of sessions.

Please note that the Priory Group accepts no responsibility for any fees not included in your treatment. These fees may include cost sharing with your PMI, patient liability, exceeding your policy limit, or insurance excess. Your Insurer can confirm if an excess payment is required to fund treatment as per the terms of your Private Medical Insurance Plan. Insurance Excess is due for payment at the commencement of treatment. More details should be obtained from your insurance provider direct.

Healthcare

Please note that if you are seeing a Consultant, this Agreement may not cover their fees as consultants usually have their own invoicing processes. For clarification please speak to the Administrator or your consultant.

Consent to treatment and an undertaking to pay must be given before an outpatient appointment can take place. Charges payable can be provided on request.

A copy of your receipt will be provided to you for your records following your sessions. Please indicate how you would prefer to receive these invoices:

Letter (post) Email Other:

DECLARATION: I hereby request and consent to private mental health treatment. I understand this is not an NHS or free service and I agree to pay the professional fees for this treatment. All applicable fees are to be settled in full at the time of my appointment.

It is my responsibility to pay the fees. However, the necessary information will be provided to my Private Medical Insurer from details provided where applicable. I understand in the event of non-payment from my Private Medical Insurer, I will undertake to settle the outstanding balance, including any excess required.

CANCELLATION FEES: Please note that should you cancel within 24 hours of your appointment, you may incur cancellation fees. This fee will also apply if you fail to attend your appointment without contacting Priory Group. On both accounts this may then result in the full fee being charged. These cancellation fees apply to all verbal/written appointments arranged at the Priory Service.

(Person with parental responsibility to sign for patient under the age of 18)

Signature	
Name in BLOCK CAPITALS	
Date	
Name of patient if under 18	

If a third party is paying for your treatment please ask them to sign below to confirm they accept this financial agreement.

Signature	
Name in BLOCK CAPITALS	
Date	