Assisted Conception Unit Patient agreement

Please ensure that you complete the agreement in full.

Patient Details

First Name ..... Surname .....

Maiden Name ..... Date of Birth .....

Town and Country of Birth ..... NHS Number .....

..... Passport Number .....

Registered Disabled Yes ☐ No ☐ ..... Ethnic Origin .....

Partner Details *(if applicable)*

First Name ..... Surname .....

Date of Birth ..... Town and Country of Birth .....

NHS Number ..... Passport Number .....

Registered Disabled Yes ☐ No ☐ ..... Ethnic Origin .....

Home Address

House/Street Name

Town ..... County .....

Country ..... Postcode .....

Tel *(Home)* ..... Tel *(Work)* .....

Mobile ..... Email .....

Have you lived in the UK for 12 months or more? ..... YES/NO

If NO please indicate below your overseas address below.

Terms and conditions

Thank you for choosing Chelsea and Westminster Hospital for your treatment.

- I have been advised of the associated fees for treatment Yes ☐ No ☐
- By signing this form I undertake to pay Chelsea and Westminster Hospital NHS Foundation Trust in respect of the services provided to me as a patient for the duration of my treatment.
- This form should be completed by the patient or his/her representative who is willing to accept full responsibility on the patient's behalf.
- I consent that I am over the age of 18. Minors must not sign this form.
- I consent that all information contained in this form is accurate and to the best of my knowledge at the date of signing.
- Payment Terms – all payments for invoices are due immediately. I understand that failure to pay my invoice in line with payment terms may result in my details of debt being passed to an external debt collection agency.
- This undertaking must be signed only by an individual accepting personal liability. It must not be signed by a TRUST, CHARITY, LIMITED COMPANY, PARTNERSHIP, LIMITED LIABILITY PARTNERSHIP, or any other corporate body.
- I understand that the cost of drugs prescribed specifically for my treatment are not covered within the package price and therefore associated costs are always the responsibility of the patient.
- Chelsea and Westminster Hospital NHS Foundation Trust participate in initiatives to monitor safety and quality, helping to ensure that patients are getting the best possible outcomes from their treatment and care. We are required to share records of the treatment that we provide with organisations including those appointed by government or by law, such as the Private Healthcare Information Network (PHIN). All information published will be in anonymised statistical form and the information will not be shared or analysed for any purpose other than those stated.Further information about how PHIN uses information, including its privacy policy, is available at www.phin.org.uk.

I consent to the above terms and conditions in relation to private care.

Signed ..... Date .....

Name in full .....

T: 020 3315 8585
E: acu@chelwest.nhs.uk • W: www.chelwest.nhs.uk/private-care

Overseas Address Details *(if applicable)*

House/Street Name

Town | County

Country | Postcode

Tel *(Home)* | Tel *(Work)*

Mobile

General Practitioner Details

Name | Practice Name

House/Street Name

Town | County

Country | Postcode

Tel No

Next of Kin Information

Surname | Title

Forenames | Relationship

House/Street Name

Town | County

Country | Postcode

Tel *(Home)* | Mobile

Communicating with you

Please confirm, for the purposes of communicating on treatment and invoicing, your preferred method of communication is:

Secure Email ☐ Post ☐ Phone ☐

Have you had treatment in another clinic?

Yes ☐ No ☐ If yes, which clinic?

Have you travelled from overseas for treatment?

Yes ☐ No ☐

Authority to retain and use money card details – private patients only
To be completed by all patients

"*I (insert full name and title)*
the undersigned hereby authorise Chelsea and Westminster Hospital NHS Foundation Trust to retain and use details of the payment cards used by me for the purposes of a deposit for planned treatment or care, or to pay for services received in respect of the sums that fall due to the Chelsea and Westminster NHS Foundation Trust. This is a revocable mandate and may be revoked by me at any time, subject to my hereby stated agreement that it may not be so revoked whilst I, or

(insert name of partner)
is in any way indebted to the Trust as regards services received.

The Chelsea and Westminster NHS Foundation Trust will issue me with a written receipt to the address provided upon each payment made."

Signed | Date

Name in full

Please ensure you complete this section *(either the patient or a guarantor)*

We understand that our Clinical Commissioning Group (CCG) will not fund any consultations, investigations or treatment, above that which has already been agreed in writing. We will undertake to pay Chelsea and Westminster for all consultations, investigations and treatments not covered by our CCG.

I *(insert full name and title)*

of *(insert house/street details)*

Town | County

Country | Postcode

Guarantee to pay any and all charges of the above named to the Chelsea & Westminster Hospital as a patient anything that I am not funded for by my local CCG, irrespective of the outcome of the treatment. I am over 18 years of age.

Signed | Date

Name in full

> NEXT STEP: *Please make sure you read the terms and conditions oveleaf (page 4) and then sign / date the form to confirm your consent.*