PATIENT CONSENT FORM

WINCHESTER SPINE CENTRE
BACK PAIN NECK PAIN SPORTS INJURIES

Name _____ Case _____

DATA PROTECTION POLICY

Under the data protection (1998) Act, we are required to advise our patients on our Data Protection Policy.
As part of the patient record, this Clinic is required to retain information for the purpose of consultation for treatment, recording subsequent treatments and for use by third party medical practitioners only, at the request of the patient, in writing.
Upon completion of the patient Details form, Data protection and consent form, all paper files and information therein may be electronically scanned and stored on computer file for as long as the patient remains a patient of the clinic; and thereafter for a period of 7 years. Alternatively paper records will be retained for the same period.
All information provided will be treated as confidential and will not be given to any other person(s)/ organisation(s) without the written consent of the patient concerned.
Information will be held both manually and electronically in files accessible only by staff of the clinic who are directly involved in the data entry and processing of patient records.

I the undersigned (or authorised guardian)** acknowledge that I have read the Data Protection Policy (above) and do hereby give consent to the practitioner / chiropractor to maintain records for the purpose outlined within the policy.

Signature: _____

Date _____

** For patients under the age of 16, a parent/guardian is required to sign.

PAYMENT

I fully understand that payment is entirely my responsibility, even if claiming through insurance.

Signature: _____ Date _____

GP Letter

It is clinic policy to write to your GP, inform them about your condition and report your progress.

I do/do not give my consent for the clinic to write to my GP

Signature: _____Date_____

Consent to Examination

I consent to an appropriate physical examination. I have seen the complaints procedure and understand that it is available to me at any time.

Signature: _____ Date _____

If you are under 16 years of age, this from should be signed by a parent/legal guardian.

2nd Visit

Consent to Treatment

I have been given a verbal report of findings at which my diagnosis and treatment plan were fully explained. I agree to treatment in the following areas:

- Neck
- Upper back
- Lower back
- Other

The risks and benefits of treatment have been explained to me and I have had the opportunity to ask questions.

I consent to chiropractic treatment.

Signed _____ Date _____

If you are under 16 years of age, this form should be signed by a parent/legal guardian.