

REGISTRATION FORM

| | |
|---------------|--|
| Client name | |
| Date of birth | |
| Address | |
| Landline | |
| Mobile | |
| Email | |

Do you agree to email correspondence to you for:

- 1) Administrative reasons such as arranging appointments - Yes/No (please delete as applicable)
- 2) Therapy-related reasons such as therapy handouts - Yes/No (please delete as applicable)

| | |
|--------------------------------------|--|
| Named person to contact in emergency | |
| Relationship | |
| Telephone number | |

| | |
|---|--|
| GP | |
| <i>Surgery name, address and telephone number</i> | |

Payment details if through health insurance. You will need to get authorisation prior to your first appointment.

| | |
|--|--|
| Health insurance provider | |
| Policy number and authorisation number | |