Cambridge Urology Partnership

Patient Name	**Home Phone Number**
Adddress	**Mobile Number**
	DOB
Postcode	**E-mail**
Medical Insurance Details: **Company:** **Membership no** **Case No**	**Referred by:** **GP:**

Please indicate that you have been given a copy of our Terms and Conditions ☐

PATIENTS COVERED BY MEDICAL INSURANCE
I understand that this is a private appointment and my Insurance provider will be contacted for payment, should they not cover the full amount of my treatment I understand that I am responsible for settling any outstanding amount.
I authorise the consultant to submit claims relating to my treatment direct to my insurer on my behalf and I understand that it is my responsibility to obtain authorisation prior to treatment.

SELF PAYING PATIENTS
I understand that this is a private appointment and I am responsible for all charges, payment may be requested in advance if full costs are known or immediately after my treatment.

PLEASE NOTE
The consultant's fees are completely separate to the invoices you may receive from the Hospital for tests or procedures carried out.

Signature..... Date.....