Havering Therapy Centre
94 North Street
Hornchurch
RM11 1SR
Tel: 01708 621111
Email: admin@haveringtherapy.com
Web: www.haveringtherapy.co.uk

Registration Form

This document is for your safety, as well as our information. If you have any questions, please ask your clinician. Thank you for your co-operation. BLOCK CAPITALS PLEASE

Full name: …… Date of Birth: ……../……../…….

Address:……

…… Post Code: ……

Contact Details:

Primary Phone: …… Secondary Phone: ……

Email address: ……

How did you hear about Havering Therapy Centre? ……

G.P. Details: (name) …… (practice) ……

……

Funding your treatment (please circle): self pay / medical insurance policy / third party claim

Insurer (e.g. BUPA): …… Membership No: …… Claim No: ……

If you are claiming all or part of your treatment costs from a health insurance policy/insurer, we would advise you to contact your provider in advance to ensure that your treatment is covered, as you may need to be seen/referred by a doctor/consultant prior to your treatment with us.

Medical checklist:

Have you had any operations? If yes, please give details……

Have you had any of the following? If yes, please tick.

Headaches	Cancer	Osteoporosis
Heart condition	Rheumatoid Arthritis	Spinal fractures
Pacemaker	Major Accidents	Other fractures
Epilepsy	Anti-coagulant therapy	Diabetes
Do you smoke?		

Are you currently seeing your doctor for any other condition? ……

Please indicate whether you could be or are pregnant (circle): [n/a] [yes] [no]

Are you taking any prescribed medications? ……

……

To the best of my knowledge these details are correct:

Signature: …… Name: …… Date: ……../……../…….

Updated: 09/06/2025

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Consent Form

BLOCK CAPITALS PLEASE

Full name: …… Date of Birth: ……

Address: …… Post Code: ……..

Please ask your Physiotherapist if you have any questions about your assessment or treatment.

( ) I consent to Physiotherapy/Podiatry assessment and treatment as deemed appropriate by the treating clinician working on behalf of Havering Therapy Centre and I consent to the collection, use, and sharing of any relevant clinical information in providing this service to you.

( ) Throughout your episode of care with us, any questions or concerns you may have about any recommended treatment must be shared with your clinician immediately so they can explain the treatment rationale and/ or modify your program appropriately. If at any time you choose not to participate in the course of treatment, please tell your clinician immediately.

Privacy Notice: We take your privacy very seriously and will take all necessary steps to protect your data and sensitive information. We comply with UK GDPR and the Data Protection Act 2018 (as amended by the Data (Use and Access) Act 2025), and all relevant medical confidentiality guidelines. Your confidential medical information will only be disclosed to those involved with your treatment. Further details can be found on our website: www.haveringtherapy.com

Your declaration and signature

By signing this form you confirm the following:

- I confirm I have read and understood the content of this consent form
- I consent to undertake an assessment and recommended treatment (if applicable) by a qualified Physiotherapist or Podiatrist registered with the Health and Care Professions Council.
- I consent to Havering Therapy Centre storing my personal and medical information, during my referral period and for as long after discharge, as is required by law
- I consent to Havering Therapy Centre sharing relevant personal & medical information with other clinicians, including my GP (if appropriate)
- I understand that I am responsible for the cost of my treatment(s) and agree to pay a cancellation fee (£30) if appointments are cancelled within 24 hours of the appointment time, or in the event of non-attendance the full treatment fee.
- Your treatment may be suspended or terminated if you fail to attend an appointment funded by a third party
- I understand that I may withdraw my consent at any time, without prejudice
- I understand that I have the right to access, correct, or request erasure of my personal data, and that I may raise any concerns about how my data is handled with Havering Therapy Centre or, if unresolved, with the Information Commissioner's Office.

Signature: …… Name: …… Date: ……..