Patient Consent Form

PLEASE FILL OUT THE DETAILS BELOW AND BRING WITH YOU TO YOUR FIRST INITIAL ASSESSMENT:

PATIENT NAME (Please Print) .... DOB: ...... / ...... / ....

ADDRESS ....

.... Post code: ....

Daytime Telephone Number: .... Mobile number (if different): ....

Email Address: ....

Patient Consent:

Bridge 38 Physiotherapy request your consent for the purpose of the General Data Protection Regulations 2018.

Personal and Medical Data:

I consent to the process of my personal and medical data on the Practice Management system, a secure encrypted electronic medical records database for patients which is managed by Bridge 38 Physiotherapy. Bridge 38 Physiotherapy clinic require these details by law, and to help us in the management and treatment of your condition. For more information on how we manage your personal data please see our **'Privacy Policy'**.

Physiotherapy Treatment:

I consent to having physiotherapy treatment by authorised Bridge 38 Physiotherapy practitioners as indicated. This treatment may involve the physiotherapist placing her hands on me and observing certain movements. I also have the right to withdraw my consent to treatment at anytime.

Email Appointment Reminders:

I am happy to receive email appointment reminders: ☐ Yes ☐ No (Please Tick one)

Marketing:

I am happy to receive Bridge 38 Physiotherapy email newsletter ☐ Yes ☐ No

and any other marketing or offers via: Email ☐ Post ☐ Telephone ☐ SMS ☐ or other means ☐ but I have the right to opt out at any time. (Please Tick all that you agree to)

Privacy Policy:

I have been made aware of the Bridge 38's Privacy Policy which is available to read on the website and in the clinic. I have the right to receive a printed version of this policy which will been given to me at my request. ☐ Yes ☐ No (Please Tick one)

Your Rights:

You also have the right to have your personal data deleted or amended on request and to withdraw treatment consent at anytime. However, we are required to retain medical notes pertaining to treatment episodes. Any withdrawal of treatment consent would result in termination of your treatment episode. Please see **Privacy Policy** for further details.

PATIENT NAME (Please Print) ....

PATIENT SIGNATURE: .... DATE: ....

If patient is under 16 or unable to understand the information contained:

PARENT/ GUARDIAN NAME ....

PARENT/GUARDIAN SIGNATURE: .... DATE: ....