REGISTRATION FORM

THE PRIVATE GP GROUP
ACCESSIBLE AFFORDABLE PRIVATE HEALTHCARE

HEALTH PLAN TIER	SILVER	GOLD	BLACK
Fees per person Monthly plan option holds a minimum term of 12 months	**£70** a year	**£35** a month / **£420** a year	**£95** a month / **£1140** a year
Family option up to 4 people Additional children charged at £10 a month or £120 a year	**£255** a year	**£70** a month / **£840** a year	**£190** a month / **£2280** a year

SECTION A - Lead person to complete IN BLOCK CAPITALS and return

Title: ___ Surname: _____ Forename(s): _____

Date of birth: _____ Address: _____

_____

Contact Number: _____ Email address: _____

Details
(please tick / circle where applicable)

Which health plan would you like to join:
SILVER / GOLD / BLACK / NO HEALTH PLAN

Which type of health plan are you joining:
INDIVIDUAL / COUPLE / FAMILY
(if COUPLE / FAMILY are selected please complete Section C)

Your preferred practice:
NEW MALDEN / HINCHLEY WOOD / WIMBLEDON / RICHMOND

Are you signing up to Direct Debit:
YES / NO
(if yes, please complete Section B)

Have all details in Section A been completed: ☐

Have read, understood and agreed to the terms and conditions available on our website: ☐

Communication
We only contact patients for the purpose of:
Appointment reminders and cancellations, information specifically relating to your health, requests for information regarding your health, sending you invoices and receipts.

Please tick if you **DO NOT** wish to be contacted regarding the above:
Email: ☐ Post: ☐ SMS: ☐

Please tick to receive communications about special offers, surveys, new services and events:
Email: ☐ Post: ☐ SMS: ☐

Where did you hear about us?
Word of mouth: ☐ Social Media: ☐ Website: ☐
Leaflet: ☐ Google: ☐

Magazine: ☐ please specify: _____

Other: ☐ please specify: _____

SECTION B - Direct Debit instructions (compulsory for members) - please complete IN BLOCK CAPITALS

Title: ___ Surname: _____ Forename(s): _____

Bank / Building society name and address: _____

_____ Sort code: _____

Account number: _____ Direct Debit in Full: ☐ Monthly instalments: ☐

I authorise payment to be taken from my account for myself and for the following family members - if applicable:

1 Name: _____ 2 Name: _____

3 Name: _____ 4 Name: _____

Please note that all invoices should be settled directly after seeing the Doctor or Nurse and before leaving the premises (unless you are part of our Direct Debit scheme).

Signature: _____ Name BLOCK CAPS: _____

Date: _____ _____

SECTION C overleaf

REGISTRATION FORM continued

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SECTION C - Additional family members, please complete IN BLOCK CAPITALS

Additional member 1

Title: ___ Surname: _____ Forename(s): _____

Date of birth: _____ Address: _____

_____

Contact Number: _____ Email address: _____

Additional member 2

Title: ___ Surname: _____ Forename(s): _____

Date of birth: _____ Address: _____

_____

Contact Number: _____ Email address: _____

Additional member 3

Title: ___ Surname: _____ Forename(s): _____

Date of birth: _____ Address: _____

_____

Contact Number: _____ Email address: _____

Additional member 4

Title: ___ Surname: _____ Forename(s): _____

Date of birth: _____ Address: _____

_____

Contact Number: _____ Email address: _____

Please tick if the family members above **DO NOT** wish to be contacted regarding - Appointment reminders and cancellations, information specifically relating to your health, requests for information regarding your health. sending you invoices and receipts.
Email: ☐ Post: ☐ SMS: ☐

Please tick to receive communications about special offers, surveys, new services and events:
Email: ☐ Post: ☐ SMS: ☐

MANY THANKS FOR YOUR INFORMATION, FROM THE PRIVATE GP GROUP