

## Outpatient Registration Form

**This section to be completed by staff:**

Consultant:

PAS No:

**The following sections to be completed by the patient  
(or guardian if patient is under 18 years of age)**

### Section A: Patient's personal details

(name and date of birth to be as recorded on passport or official documentation)

Title:

Surname:

Forenames:

Date of birth:

Next of Kin:

Relationship:

Contact number:

UK address:

Postcode:

Mobile Tel:

Home Tel:

Work Tel:

Email:

Overseas address: (if not UK resident)

Nationality:

Passport No:

Expiry date:

GP name:

Optometrist Name:

GP address:

Optometrist address:

## Section B: Method of Payment

Please indicate how you are paying for your treatment (tick box)

Credit/Debit card:

Embassy:

Other guarantor:

Private Medical Insurance provider:

Membership number:

Scale of cover:

Pre-authorisation code:

Please indicate by circling Yes or No if you have received written confirmation of the consultants fees prior to your consultation.

Yes

No

### Declaration by patient (or guardian if patient is under 18 years of age)

- I hereby undertake to pay Moorfields Eye Hospital NHS Foundation Trust for all services and materials relating to my/the patient's private diagnosis and treatment (e.g. consultations, tests, examinations, accommodation etc.) irrespective of the outcome of the treatment.
- I understand that the account will be referred to the Trust's recovery agents if unpaid within the Terms of Business and that all the above details will be made available to the said Recovery Agents. This authority is unconditional and irrevocable.
- I understand that for the purposes of security, the Trust reserves the right to instruct an appropriate agency to verify the patient's and/or my address. Such an enquiry will be recorded on the agency's file and may be shared with other users.
- I understand that if I am not ordinarily resident in the UK, the Trust and/or the Recovery Agents reserve the right to contact British Government missions abroad for the purposes of confirming and/or verifying the information provided regarding the next of kin, guarantor, visa sponsor and/or me.
- I authorise the Moorfields Eye Hospital NHS Foundation Trust to submit claims relating to my diagnosis and/or treatment to my insurer/guarantor on my behalf.
- Notwithstanding the provisions of my personal undertaking, I agree to assign to the Trust any of the rights to be paid for hospital or other related charges by the insurers/guarantors in respect of the current episode of treatment provided.
- I authorise the disclosure of appropriate medical records, including copies if necessary, to the insurer/guarantor as part of their claim and payment processing requirements.
- I agree to accept full liability and I fully understand that being insured does not mitigate my legal responsibility to settle in full any shortfall or the account rendered and within the terms stipulated in this form, in the Terms of Business for private patients, and on the Trust invoice.
- I hereby authorise the Trust, or its authorised agents, to make enquiries with my/the patient's insurers or guarantors to confirm the extent of, and the limits to, my/the patient's health insurance policy as related to the proposed treatment.

## Section C: Data Protection

- **Confidentiality:** The confidentiality of patient information is of paramount concern to Moorfields Eye Hospital NHS Foundation Trust. To this end, the Trust fully complies with Data Protection Legislation and Medical Confidentiality Guidelines.
- **Medical Information:** Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care, or to their agents and, if applicable, to any person, organisation or their agents who may be responsible for meeting your treatment expenses
- **Research:** Anonymised or aggregated data may be used by the Trust or disclosed to others, for research or statistical purposes.
- **Moorfields Eye Charity:** Charitable support is vital to the research and services that Moorfields Eye Hospital NHS Foundation Trust (MEH) is able to carry out. Moorfields Eye Charity supports MEH and our research partners at the University College London (UCL) Institute of Ophthalmology, making a difference for patients at the hospital and for people with sight problems around the world. The Charity would like to send you information on its work and how you can support it. They would also like to share your data with UCL solely for the purpose of related fundraising activities.
- If you would rather your name and address were not shared for these purposes, (including creating a profile of your interests, preferences and analysing your ability to provide financial support) you are able to opt-out. If you would like to opt out, please email: [eyecharity@moorfields.nhs.uk](mailto:eyecharity@moorfields.nhs.uk) or write to the following address, ensuring you include your full name and address: Moorfields Eye Charity, 162 City Road, London EC1V 2PD.
- **Access to Non-medical Information:** We use your non-medical personal details (e.g. name and address) to give you the information and support you ask for, and for products and services that the Trust consider may be of interest to you to be brought to your attention. We may also use this information for administrative purposes and to let you know about changes to our services and policies.
- **Third Party Disclosure and Fraud:** We will not sell your details to any third parties but we may sometimes share your details with our trusted service providers who are authorised to act on our behalf, such as those that manage our patient satisfaction surveys and associated organisations (who work with us to get the information you ask for). In addition, from time to time, we may exchange your personal information with other organisations for the purpose of fraud and credit risk reduction. In these circumstances we always require strict compliance with our instructions and, in the case of third party organisations, require that your personal information is not used for their own business purposes.

**I do not consent to my information being used for the purposes detailed in Section C.**

**Signature:**

**Date:**

**Contact details (if different from patients):**

**Address:**

**Preferred contact number:**

**Email:**