



CONSENT FOR TREATMENT/CARE

I confirm that the information provided in the medical history form true and correct to the best of my knowledge. I have read and understood the 'Informed Consent' form and agree to proceed with care at Sensus Health.

Signed: _____ Date: _____

FEES

I understand that I need to give **24 hours advance notification** to cancel or change an appointment(s) and if I fail to do so, shall be liable for the full cost of the treatment and any additional administration or legal fees to recover the debt.

Signed _____

Date: _____

DATA PROTECTION POLICY

Under the Data Protection (1998) Act, we are required to advise our patient(s) on our Data Protection Policy.

As part of the Patient Record, Sensus Health & Wellness Ltd is required to retain information for the purpose of consultation for treatment, recording subsequent treatments, and for use by Third Party medical practitioners only, at the request of the patient, in writing.

Upon completion of the Patient Health Record Form, Data protection and consent form, all paper files and information herein may be electronically scanned and stored on a computer file for as long as the patient remains a patient of the Clinic, and thereafter for a period of 7 years. Alternatively papers records will be retained for the same period of time.

All information provided will be treated as confidential, and will not be given to any other person(s) / organisation(s) without written consent of the patient concerned.

Information will be held both manually and electronically in files accessible only by staff of the Clinic who are directly involved in the data entry and processing of patient records.

I the undersigned (or authorised Guardian) acknowledge that I have read the Data Protection Policy (above) and do hereby give consent to the Practitioner/Therapist to maintain records for the purpose outlined within the policy.

Patient: _____
(PRINT NAME)

Patient: _____
(SIGNATURE)

Date: _____