Dr Michael Rowlands
Consultant Psychiatrist
13 White Beam Way Tadworth Surrey KT20 5DL

Outpatient Registration Form

Tel no: 01737 812211
Email: trudy@drrowlands.co.uk

Title	Patient Surname	
Sex	Forename(s)	Date of Birth
Address Post Code		

Tel Number (Day)	Tel Number (Night)
Mobile Number	Email Address:
Alternative Billing Address:	

We require Credit Card/Debit Card Details

Bank Transfer Details: Can be supplied if needed Is there an excess to be paid? How much ?	Debit / Credit Card ☐ Valid From..... Issue No (Switch) ☐ Expiry Date..... Card Number..... Please sign below if you wish charges to be deducted from your card Signature.....

Medical Insurance Company Name
Policy Holders Name
Membership Number
Pre Authorization Number

Undertaking

I hereby agree to pay Dr Rowlands for all services relating to my treatment as a patient including when Medical Insurance proves not to cover the course of the treatment. I agree to Dr Rowlands storing these details

Signature of Patient	Date
.....	.....