

145 Harley Street  
 London  
 W1G 6BJ  
 020 7486 3840 (tel)  
 020 7486 3810 (fax)  
 stpeters@andrology.co.uk



**MEDICAL DIRECTOR**  
**David Ralph** BSc MS FRCS(Urol)  
 Consultant Uroandrogologist

**Nim Christopher** MPhil FRCS(Urol)  
 Consultant Uroandrogologist

**John Dean** FRCGP  
 Specialist in Sexual Medicine

**Philip Kell** FRCOG FACSHF FRCP(I)  
 Consultant Genitourinary Physician

**Mandi Spillings** RGN BSc(Hons)  
 Nurse Practitioner

**PRACTICE MANAGER**  
**Andy Pryor** BA(Hons)

## Registration Form

Your Details		Your Partner's Details	
Family Name: .....		Family Name: .....	
First Name(s): .....		First Name(s): .....	
Title: .....	Date of Birth: .../.../...	Title: .....	Date of Birth: .../.../...
Occupation: .....		Occupation: .....	
Your Address (where reports and/or appointments should be sent)			
Address: .....		Tel (daytime): .....	
.....		Tel (evening): .....	
.....		Tel (mobile): .....	
Postcode: .....		Email: .....	
Your Doctors' Details (who you want kept informed of your treatment)			
General Practitioner	Referring Doctor (if not GP)	Other Doctor/Clinic	
Name: .....	Name: .....	Name: .....	
Address: .....	Address: .....	Address: .....	
.....	.....	.....	
.....	.....	.....	
Postcode: .....	Postcode: .....	Postcode: .....	
Payment Details (please complete both boxes)			
Insurance Details (if any)		Credit/Debit Card Details (Not American Express)	
Insurance Company: .....	.....	Card Type (eg Mastercard/Visa): .....	
Scheme/Scale: .....	.....	Card Holder: .....	
Registration Number: .....	.....	Card Number: .....	
Group Number: .....	.....	Expiry Date: ..... / ..... Issue Number: ..... (if present)	
Preauthorisation Code: .....	.....	Valid From: ..... / ..... Security Code: ..... (last 3 digits)	

I have received a copy of the payment terms and authorise deduction of due amounts from the above card.

I consent to details of my treatment being provided to my insurance company as detailed above and do (NOT)\* wish to see such information before it is sent to them.

**Signature:** ..... **Date:** .....

COPY

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## Payment Terms

- Payment is due at the time of treatment.
- We will normally be able to let you know the cost of your treatment in advance. Where this is not possible (for example if an exploratory procedure is being performed) then he will be able to give you a range of possible charges.
- There may be other charges incurred by you in the course of your treatment which will be charged to you by the party concerned (eg: hospital, anaesthetist, blood tests)
- Payment by credit/debit card will be processed when due. This will appear on your statement as "Dr D J Ralph". Alternatively, payment can be made by cash or cheque made payable to 'St Peter's Andrology Centre' at the time of treatment.
- A receipt is generally only sent if requested.

### **Medical Insurance**

- You are advised to check with your insurance company before any treatment.
- Provided that you give me your insurance details together with either a signed claim form or preauthorisation number we will normally be able to invoice your insurance company direct.
- Any shortfall due once the insurance company has assessed the claim will be charged to your credit/debit card as outlined above.
- You may prefer to pay by cash or cheque, in which case a deposit will be payable at the time of treatment pending assessment by the insurance company.

### **Other Third Parties**

- If a third party (eg: embassy or company) is to pay for your treatment then we will require a letter of guarantee. You should contact my secretary to arrange this in advance of any treatment.

### **Administrative Charges**

- We reserve the right to charge a cancellation fee for repeated non-attendance.
- Any additional charges incurred in collecting amounts due will be added to your bill.

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**Please keep this sheet for your own record**

18/07/2008