AGREEMENT TO PAY FORM (FOR PRIVATE PATIENTS) Form Number:

PATIENT INFORMATION AND CONTACT DETAILS

Name		Title		Date of Birth	DD / MM / YYYY
Street Address					
Postcode		Mobile			
Email					

PROCEDURE DETAILS

CCSD Procedure Code		Procedure or test description / name	
Date of procedure or diagnostic test	DD / MM / YYYY	Name of consultant in charge	

SELF-FUNDED PAYMENT OR INSURANCE POLICY DETAILS

Insurance company	INSERT NAME OF INSURER OR STATE "SELF FUNDING"	Membership / policy number	INSERT OR STATE "NOT APPLICABLE" IF "SELF FUNDING"
Treatment authorisation code	INSURANCE COMPANY PROVIDE THIS	Package price (if applicable)	£
Consultants' fees	Included / Not included / Unsure *(NB Fees and package price are confirmed in Quote Letter)*		

HOSPITAL USE ONLY

MRN		NHS Number		Site	

DECLARATION

It is very important that you read our terms and conditions and understand them. Our terms and conditions are available on the hospital's website at www.gloshospitals.nhs.uk/private-patient-tcs
They contain important information about the hospital, the basis on which we will provide services to you, how we will charge you for these services, how we may change or end our agreement with you, what happens if there is a problem and other important information. Please ensure that you read these in full before you sign this form.
If you're unable to access that website or would like a printed copy of these terms and conditions sent to you, please contact the Private Patient team (Monday to Friday, 0800-1600) by calling either 0300 422 3138 (for treatment at Cheltenham Hospital) or 0300 422 6880 (for treatment at Gloucestershire Hospital) or emailing ghn-tr.private.patientbookings@nhs.net Please also contact the Private Patient team if you have any questions about our terms and conditions before you sign this form.

I agree to pay all charges for hospital accommodation, treatment and services provided to me (and all and any other associated costs and expenses) as a private patient at Gloucestershire Hospitals Trust, irrespective of the outcome of the treatment. I understand that if I am insured this does not mitigate my legal responsibility to pay the account (or shortfall) if for any reason my claim is rejected by my insurance company. I understand that the account will be referred to the Trust's Recovery Agents or other approved Debt Collection Agents in the event of non-payment and that all the above details will be made available to them. This authority is unconditional and irrevocable.

Date signed	DD / MM / YYYY	Signature	

If you're signing on behalf of a patient – for instance as their carer or guardian - then please include your details below

Name			
House number & postcode			
Email			
Mobile		Relationship to patient	