|  |  |
| --- | --- |
| DR ANDREAS SCHENK M.B.B.Ch., FCPsych**Nuffield Health Bournemouth Hospital** 67Lansdowne Road, Bournemouth , BH1 1RW**Priory Hospital Southampton**Marchwood Park, Marchwood, Southampton, SO40 4DA Email: info@southernpsychiatry.com**PLEASE COMPLETE ALL SECTIONS IN FULL** | **CLIENT DETAILS AND CONSENT FORM (amended April 2024)**Tel: 07501 911576 |

# 1) CLIENT (PATIENT) DETAILS

**Title ……… Surname: ………………………………………………………………………………………………**

**Forenames……………………………………………………………………………………………………………….**

**Date of Birth ………………… ID No. (Passport/Driver’s Licence): ….…………………………….**

**Residential Address: ……………………………………………………………………………………………………**

**………………………………………………………………………. Postcode ……………….……….**

**Telephone (H) ………..………………….**

**(W) ..……..…………………..**

**(M) ……..……………………**

**E-mail Address ……………………………………………………..**

**Are you in agreement with us communicating with you via email? Yes 🞎 No 🞎**

**General Practitioner’s name: …………………………………**

**Address of GP: …………………………………………………………………………………………………………….**

**………………………………………………………………………. Postcode………………………..**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 2) FAMILY

**What is your present marital status? ……………………………**

**What is the name of your spouse or partner? ………………………………………………………………………..**

# Names and Ages of Children:

# Names and Ages of Brother and Sisters:

**Has any relation been seen by a Psychiatrist or suffered from a Psychological/Neurological illness? ( please specify)**

**………………………………………………………………………………………………………………………………..**

# 3) EDUCATION AND EMPLOYMENT

**After leaving school, did you take further full time education?** Yes 🞎 No 🞎

If yes, please specify and say to what qualifications it led: ………………………………………………………………..

# What posts have you held in the last ten years ?

Job Title Employer From To Reason for leaving

……………………. ………………………….. ……. …..…. ..………………………………….

……………………. ………………………….. ……. …..…. ..………………………………….

……………………. ………………………….. ……. …..…. ..………………………………….

# 4) MEDICAL INFORMATION

**Please list all the names and doses of medication you are currently taking:**

**……………………………………………………………………………………………………...……………………………**

**……………………………………………………………………………………………………...……………………………**

**Current contraception: ………………………………………………………………………………………….**

**Please list all physical illnesses and any admissions to hospital:**

Diagnosis or Symptoms Age Treatment Where Treated

…………………………………. ……. …………………………………..…… …………………………………...

…………………………………. ……. ………………………………………. …………………………………...

# Please list any previous psychiatric/psychological treatments:

Diagnosis or Symptoms Age Treatment Where Treated

…………………………………. ……. …………………………………..…… …………………………………...

…………………………………. ……. ………………………………………. …………………………………...

**How many total units of alcohol do you consume in a week?** …………….

*(A standard glass of wine is approximately 2 units. A pint of beer/lager is approximately 3units. 275ml bottle of alcopop is approximately 1.5units)*

**Do you take any other recreational substances/drugs (including aspirin, cold remedies etc) that have not been prescribed for you?**

 **Yes 🞎 No 🞎**

If yes, please specify …………………………………………………………………………………

# 5) GENERAL

**Are you, or have you ever been in conflict with the law?** **Yes 🞎 No 🞎**

**Have you ever attempted to take your own life?** **Yes 🞎 No 🞎**

**Have you ever harmed yourself deliberately?** **Yes 🞎 No 🞎**

**Have you had any thoughts of harming yourself in the last 12 months? Yes 🞎 No 🞎**

**Have you had any thoughts of harming others in the last 12 months? Yes 🞎 No 🞎**

**Have you had any difficulty looking after your own basic day to day needs (eg. eating/washing/dressing) in the last 12 months? Yes 🞎 No 🞎**

**Have you required any assistance from the NHS Psychiatry Services in the last 12 months?**

 **Yes 🞎 No 🞎**

**If you have replied Yes to any of the above, please provide full details below:**

**………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………….**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# 6) INFORMATION SHARING, PRIVACY AND DATA PROCESSING AGREEMENT

**Dr Schenk is committed to protecting you privacy and maintaining your confidentiality and does not share your data with third parties for marketing purposes. In order to provide you with an effective clinical service your personal and clinical data will be stored on secure servers of Cliniko, Nuffield Hospital and the Priory Hospital. Cliniko is a secure online medical practice management/accounting system which processes patient data outside of the EU/EEA zone but offers sufficient safeguards and protection to otherwise meet data protection requirements. Your data will also be stored on secure cloud based storage servers such as Tresorit. Dr Schenk will share your personal data/clinical information with your referring GP or other clinicians/therapists that you agree to be referred to or are directly involved in your care. Your data will be processed on computers belonging to Dr Schenk and his secretary and stored thereon only for as long as is necessary to fulfil clinical/legal/accounting requirements. Your clinical information, once anonymised, may be used by Dr Schenk, the Priory Hospital or the Nuffield Hospital for clinical audit, care quality improvement or education.**

**I consent to my personal/clinical data to be shared with the following individuals/agencies:**

**1)………………………… Tel: ……………………… 2)…………………………. Tel…………………………**

**3)………………………… Tel: ……………………… 4)…………………………. Tel…………………………**

**I consent to my personal and clinical data being processed as described above: Yes 🞎 No 🞎**

**Signature of Client:** …………………………………………. **Date:** …………………………….

**7) PAYMENT TERMS AND CONDITIONS**

**This Section needs to be filled in by all patients. Please read terms and conditions carefully.**

**Please note that you are personally liable for any outstanding bills/excesses not covered by your Medical Insurer.**

**By signing below I agree that I am over 18 and personally responsible for settlement of all my accounts and will pay Dr Andreas Schenk Ltd for any services provided by/consultations booked with Dr Andreas Schenk. I accept that consultation fees are subject to change with time and that by booking an appointment I accept the consultation fees applicable at the time of booking. I understand that additional professional fees will be charged for extra services such as phone calls, email communications, reports or letters. I understand that I need to settle any accounts within 10 days of attending consultation or issue of invoice and that administrative fees, statutory interest and debt collection fees may be added to invoices which are more than 30 days overdue. I understand that I may be charged in full for any booked consultations which I do not attend or which I don’t cancel in excess of 48 hours before the scheduled appointment. I understand that, although claims may be submitted directly to a medical insurance on my behalf, I remain personally responsible for settlement of any accounts not paid or covered by medical insurance. I authorise Dr. Schenk Ltd. or its agents to submit claims relating to my treatment to the insurance company on my behalf. If required by my medical insurance company to assess a claim, I consent to my insurance company obtaining a medical report from Dr Schenk as to the history and nature of my condition or its treatment. I have been notified of my rights under the Access to Medical Reports Act 1988. I agree that a copy of this consent shall have the validity of the original.**

 **Dr Schenk’s current professional fees (subject to change) are:**

* **First Standard Consultation (Assessment, including clinic letter): £450; Follow Up Consultation (up to 30 mins, including clinic letter): £250; Extended Follow Up Consultation (up to 60 mins, including clinic letter): £400.**
* **Additional Professional Fees (including phone calls, email communications, liaison with other professionals, reports or letters): £120 per 20 minutes or part thereof; Private prescription: £25; Brief Letter: £50.**
* **For CAA format assessments/reports the basic charge is £480 for Initial assessment and CAA report and CAA follow up assessments/reports are £270.00.** **There will be an additional charge for documentation review of £120 per 20 minutes or part thereof. These fees are payable in advance for both self-funding and insured CAA clients, the latter by way of a deposit of £600 which will be refunded once payment has been received from the insurer.**

# Signature of Client: …………………………………………. Date : …………………………………

# Name of Medical Insurance Company :………………………………………………..

# Policy No: ……………………………………. Authorisation No: ………………………………………

# I do (not) wish to see the medical report before it is sent to my insurance company (Delete the word (not) if you wish to see the medical reports)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_