Private Patient Agreement:

I have received, read and accept the terms laid out in the following documents:

- Insured and Self Pay Patient Payments Agreement Version 1

And

- Data Protection Statement Version 1

I am / am not willing to receive medical and invoicing communication by standard / un-encrypted email (patient please delete as appropriate).

I am / am not willing to have my medical record securely stored on an HIPAA compliant cloud based storage system (patient please delete as appropriate).

Patient Signature: ________________________________ Date: _______

Patient Print Name: ________________________________

Consultant Signature: ________________________________ Date: _______

Consultant Print Name: Dr Justin Carter