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PATIENT ACCESS APPLICATION FORM

| | PATIENT ACCESS AFFLICATION FORM | 0111 1737 |
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| Name | | |
| D.O.B. (over 16 yrs only) | | |
| e-mail | | |
| Address | | |
| Mobile number | | |
| routine appointments a Medical Centre details disclose these details t and I undertake to gi telephoning the surger cannot be used to rais Patient Access accoun | and order repeat prescriptions over the Internet. I accept the terms and conditions of The Aced below and I undertake to keep my user name, PIN, User ID, and password confidential to any other person. I understand that I am limited to booking a single appointment at any ive as much notice as possible if I need to cancel an appointment (either via the Intervy). I understand that use of the Messaging Service is restricted to administration queries se or discuss any clinical matters. I understand that any reply from the practice will be sent and not my registered e-mail address. I understand that any change of contact details registered to approval by the practice and if I move out of the practice area, I will need to register my new address. | Addington and not to y one time ernet or by as only and sent to my |
| | failure to comply with these terms or other misuse of the system may result in The | Addington |
| Medical Centre termin | nating my use of the Patient Access system. | |
| Service Provision by The While we will make all r full, for any cause that maintenance and upgrad secret. You must take all the Service from time to your protection, suspend practicable if we take sur We reserve the right to we | Date | oulting from onal Details at to change of for you or soon as is able notice. |
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