# **Registration with Kim Weir (Sports Massage Therapist)**

As I am a registered practitioner, in order to practise and charge a payment for my services, I have several requirements placed upon me by my registering body and insurer.

These include taking personal information from you and storing that information for at least 8 years.

The information I hold is not shared without your permission.

If you ask me to write a letter of referral, I will share your name, DOB, address and any relevant clinical information, that I deem necessary, with the person I am referring you to.

If you have come to see me because of an incident that has involved an insurance claim, I am obliged to share your name, DOB, Address and any information relevant to your claim with the insurance company.

As I will only instigate these referrals at your request, this will imply that I have your permission to share the relevant data with the person / company you have asked me to contact.

I will also use your contact information for the following purposes:

1. To confirm or remind you about an appointment you have with me
2. To inform you of any practise changes (changes to clinic, appointment times, price changes)

If, for any reason, other occasions arise that involve your details (e.g. instigation of a newsletter), I will confirm your acceptance before sending on to you.

Please can you sign this as acknowledgement and acceptance of how I will use your information.

Many thanks,

Kim Weir (Sports Massage Therapist FSMT (Assoc) LCSP (Assoc)

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Telephone no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­of signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preference for contact (please circle preferred choice) Email / Telephone