CityPraxen BERLIN

Privatpraxen

Dear patient,

We kindly ask you to complete this questionnaire carefully in order to provide you with a comprehensive service.
Thank you very much.

Your practice team

Friedrichstraße 180 • 10117 Berlin
Telefon: 030 / 886 226 - 0
Telefax: 030 / 886 226 - 309
E-Mail: info@citypraxen.de
www.citypraxen.de

Family name	First name	DOB
Address	Zip code, City	State
Landline number	Mobile number	
Profession / Occupation	E-mail (will only be used for personal messages – no advertisement)	
Health insurance	Insurance number	

Please inform the following physician about diagnostic findings and medical treatment:

Physician	Address	Phone / E-mail

If I am not available, please contact the following person in case of emergency:

Name, First name	Relation	Phone / E-mail

Declaration of consent

- Your health insurance has informed you of your health insurance plan restrictions and exclusions. I am aware that all consultations at CityPraxen[BERLIN] are billed according to the tariff of German Doctor's Association (GOÄ). Therefore, the basic tariff rate can be increased by three and a half times and cannot be waived by unilateral announcements. Oral side agreements do not apply. In bilingual documents, in case of doubt, the German text is valid.
- You hereby agree, until revoked in writing, that your personal data and medical information will be stored at CityPraxen[BERLIN] in compliance with the German legal requirements and will be available to all health professionals who may provide treatment at CityPraxen[BERLIN].
- Messages and diagnostic findings may be sent to me by E-Mail.

Berlin,

Place, Date	**Name (in block capitals)**	**Signature**

PVS berlin-brandenburg-hamburg
EIN UNTERNEHMEN DER PVS HOLDING

Declaration of Consent/Authorization for Release of Medical Records

(Einwilligungserklärung/Schweigepflichtentbindungserklärung)

Dear Patient,

The PVS berlin-brandenburg-hamburg GmbH &Co. KG (PVS), Invalidenstr. 92, 10115 Berlin will settle the invoice for the medical/ therapeutic services, create the invoice and collect the fee claim from you. As an independent company, PVS is part of the PVS holding GmbH group of companies, which is also its parent company. The parent company manages the bookkeeping on behalf of PVS, provides the IT infrastructure including maintenance and support as well as the printing and mailing of written communications. As part of necessary data processing, PVS is available as data protection managers to protect your rights and answer your inquiries.
The employees of the aforementioned companies are professionals entrusted with confidential information and are subject to professional secrecy and the provisions of data protection in the same manner as a doctor. The fee claims are assigned to and held in trust by PVS. PVS creates the invoice in its own name, collects the fee claim on its own account and is available to you as the contact person. Until final payment of the total amount of the fee claim, PVS is subject to the instructions of the service provider, who also in this respect, retains ultimate control of the invoicing process. With your signature, you consent to the assignment of the fee claim and to data processing for the purposes of invoicing, collection of fees and evaluation of the medical work. Your personal treatment data, such as address, date of birth, cost bearers, any charge rates, days of treatment, services provided according to the scale of charges and related diagnoses, will be transmitted to the PVS companies mentioned above. Of course, your treatment does not depend on this consent. You can also exclude individual treatments from this declaration. Then the service provider would have to do the invoicing itself. This does not result in any disadvantages to you. You can revoke your consent at any time with future effect. The legality of the data processing prior to revocation is not affected. Your data may then be further processed to the extent required by law. The revocation can be submitted to the service provider or PVS by means of a written declaration stating your name and address (if applicable invoice number). This also does not result in any disadvantages to you. Further information about data protection at PVS and about your rights can be found at: www.ihre-pvs.de/datenschutz.

I hereby consent to the processing of data by PVS for the aforementioned purposes and in this respect release the service provider and its professional agents at the same time from their duty to maintain medical confidentiality.

_____ _____

Date (Datum) Signature Patient (Unterschrift Patient/in)

Registration for Private Patients (Anmeldung für Privatpatienten)

Patient

Name (Name) First Name (Vorname) DOB (geb. am)

Party Liable for Payment/Invoicing Address (Zahlungspflichtiger/Rechnungsempfänger)

Name (Name) First Name (Vorname) DOB (geb. am)

Occupation* (Beruf) Tel. accessible* (tel. erreichbar)

Street Name (Straße) E-mail address* (E-Mail-Adresse)

ZIP Code (PLZ) City (Wohnort)

Employer* (Arbeitgeber)

Health Insurance Company/Cost Bearer* (Krankenversicherung/Kostenträger) Tarif*

Family Doctor/Referring Doctor* (Hausarzt/überweisender Arzt)

*** This information is voluntary. There are no disadvantages if you do not provide this information. However, it may be helpful if you are available by phone.**