Treatment contract for private patients / self-payers

Between

the PRIVATE DOCTORS OFFICE FOR HOLISTIC MEDICINE Dr. med. Christin Gramsch

Seestrasse 36, 17429 Seebad Bansin

and surname, first name (of the patient)

birth date

Surname, first name of legal guardian (for children under 18 years of age)

Streets, house number, city, zip code

phone number

E-mail address

Patient

Dear patient, dear parents,

Please read our treatment contract carefully, ask any questions you may have and confirm your agreement with your signature.

I try to keep waiting times short and schedule appointments as quickly as possible. So I am also dependent on your reliability in meeting the deadlines. Please cancel appointments at least 24 hours in advance, otherwise I am entitled to charge a cancellation fee.

My billing is based on the guidelines of the fee schedule for doctors GOÄ. The medical association obliges me to do this. As a rule, the 2.3-fold rate is charged, the first anamnesis and long follow-up appointments are charged at the 3.5-fold rate. Most of my bills are reimbursed in full by private health insurance companies and aid agencies. However, it can happen that individual insurance companies (or individual clerks) refuse to reimburse one or the other number (usually for reasons that are difficult to understand). It is noticeable that if those affected object, they are usually reimbursed. At this point it is important for me to point out that it is your responsibility to clarify the assumption of costs with your private insurance company, whereby I can of course support you with a small certificate. The time for the discussion between doctor and patient is often not covered by health insurance and some decisions that are important for your health and life are made under time pressure. For this and for other complementary holistic therapy methods, we have set up analogue digits that you may have to carry yourself. The list of analogue digits is in the waiting room. If laboratory values have to be collected, these will be invoiced to you separately by the laboratory.

For the sake of completeness, it should be mentioned here that the payment for my service is due when the invoice is issued and that you undertake to pay the treatment costs.

With my signature, I confirm my agreement with the above points. Place, date Patient's signature

Data protection declaration of consent for the processing of personal data in accordance with Art. 6 Para. 1 Letter A) Art. 7 DSGVO

I agree to the storage of my personal data by the medical practice Dr. medical to Christine Gramsch. I also agree that my data will be passed on to the cooperating laboratories if this is necessary. With my signature, I give my consent to the transfer of data to the family doctor or other doctors, if necessary. I agree that the medical practice Dr. may contact Gramsch by telephone, fax and e-mail. I have been informed that I can revoke my consent at any time in writing or by email to the practice. I am aware that my revocation of consent, which is possible at any time, does not affect the legality of the processing carried out on the basis of the consent up to the time of revocation.

Place, date Patient's signature