FO 05-664-00 • Version 1.2

Doctor's Stamp

Application Form for Private Patients

Patient's Surname and First Name

Date of Birth

Surname and First Name (Payer / Invoice Recipient)

Date of Birth

Street

Postal Code /City

Private Phone Number

Office No. / Mobile Phone

Cost Bearer / Health Insurance

tariff

Employer (optional)

Job (optional)

Family or House Doctor / Referring Doctor

Doctor's Stamp

Formal Written Consent

acc. to §4a Bundesdatenschutzgesetz/Federal Data Protection Law
(forwarding of information of personal data)

Die PVS®
Schleswig-Holstein · Hamburg
Ärztliche Gemeinschaftseinrichtung

Moltkestr. 1
23795 Bad Segeberg
Tel.: 04551-809-0
Fax: 04551-809-6180
www.pvs-se.de
info@pvs-se.de

Dear Patient,

my/our invoice processing is undertaken by the PVS/Schleswig-Holstein • Hamburg rkV. Thanks to this support we can considerably relieve us and our personnel of administrative work, so that we can spend more time and attention to our patients. The PVS has been founded as medical/dental community association already in 1926. The PVS is managed by medical directors and always works in accordance with the doctor's instructions. In consequence of § 203 StGB (German penal code) the personnel of the PVS is - like any doctor/dentist - obliged to maintain confidentiality and to comply with the German data protection law.

We kindly ask you to entitle us by your present signature, to forward any data necessary for a correct processing of invoices, especially address, date of birth, name of cost bearer, treatment dates, services provided as to the description in the doctor's fee schedule (GOÄ) and the according diagnoses to the PVS and to assign the payment claims to the PVS for collection purpose. Of course, your consent is revocable in any individual case.

In addition we kindly ask you for your written consent (by present signature) to the forwarding of the necessary medical data to other attending physicians and to institutions or physicians, involved in eventual special medical examinations (laboratory, taking of tissue samples, x-ray examination etc.)

I hereby declare my consent:

Surname, First name (of Patient)

Date of Birth

Place, Date

Signature of patient or legal representative/s