OCM Orthopädische Chirurgie München

PATIENT REGISTRATION FORM

Dear patient,
we are delighted to welcome you to the OCM! First, however, we require your assistance: please complete this patient registration. All the information you provide will naturally be treated in the strictest confidence and in accordance with data privacy laws.

1. PERSONAL INFORMATION

Surname

First name(s)

Date of birth

Address

Gender m/f/w

Post code/city

E-Mail

Telephone

Mobile

Occupation/profession

Employer

Telephone (at work)

2. YOUR HEALTH INSURANCE

- ○ Statutory insurance
- ○ Private insurance
- ○ Supplementary private in-patient insurance
- ○ Cost reimbursement procedure
- ○ Self-paying patient

Health insurance

Health insurance number

Primary insured person

Date of birth

3. ONLY IN THE CASE OF PRIVATE INSURANCE OR SUPPLEMENTARY PRIVATE INSURANCE

Health insurance

Health insurance number

- ○ Senior consultant treatment
- ○ Treatment in hospital by own general practitioner
- ○ Single room
- ○ 2-bed room
- ○ Multi-bed room
- ○ Reduced rate
- ○ Eligible for financial aid

Fee rate

Financial aid authority

OCM Orthopädische Chirurgie München

Is there any person/agency authorised to provide information about you? Name _____ Date of birth _____

Have you had an industrial accident, a commuting accident or an accident at school? ○ yes ○ no

If yes: name of professional association/industry in which you work _____

Do you require nursing care? ○ yes ○ no Care level: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

4. PERSONS ENTITLED TO RECEIVE INFORMATION

4. ONLY FOR PATIENTS WITH PRIVATE INSURANCE

- I am aware that my insurance company and/or the competent financial aid authority may in certain cases not reimburse the full invoice amount even if the invoice has been issued correctly in accordance with the GOÄ (German medical fee schedule).
- I undertake to pay the amount invoiced in accordance with the GOÄ (German medical fee schedule) in full, regardless of the amount reimbursed by my insurance company and/or the competent financial aid authority. The doctor's obligation to charge for medically necessary services in accordance with the GOÄ regulations remains unaffected.

Munich, _____ Date _____ Signature of patient or legal representative

5. DECLARATION OF CONSENT

Declaration of consent to the collection and transfer of patient data in accordance with §73 Section 1 b SGB V.

I hereby give my consent for
- my attending doctor to forward my treatment data and diagnostic findings to referring doctors or further treatment facilities (e.g. rehabilitation clinic) for the purposes of further treatment and documentation
- my attending doctor to obtain from my referring doctor or other doctors or service providers the treatment data and diagnostic findings necessary for my treatment and to process and use them for the purposes of the medical services to be performed
- I am aware that I can withdraw this declaration of consent at any time in whole or in part for the future
- my attending doctor is not permitted to forward, process or use my treatment data and diagnostic findings for any purposes other than those stated above

Note: for reasons of data privacy laws, the OCM is not permitted to send medical documentation and/or diagnostic findings via e-mail.

Munich, _____ Date _____ Signature of patient or legal representative

DECLARATION OF CONSENT FOR ELECTRONIC HEALTH RECORD (EHR)

Declaration of consent regarding use of the health record pursuant to Article 339 (1) of Volume 5 of the German Social Insurance Code (SGB V), Articles 346 – 348 of Volume 5 of the German Social Insurance Code (SGB V).

I hereby give my consent for
- my attending doctor to transmit my treatment data and diagnostic findings to the EHR for use by me and by certain persons authorized by me to access them
- the doctor treating me to receive access to the health data stored in my EHR to the extent of my approval and to process and use it for the purposes of the medical services to be provided
- I am aware that I am entitled to have data transmitted to and stored in the EHR
- I am aware that I can revoke this declaration in full or in part at any time for the future
- my attending doctor may not transmit, process or use my data stored in the EHR for any other than those purposes mentioned above

Munich, _____ Date _____ Signature of patient or legal representative

Thank you for your cooperation.