Gemeinschaftspraxis für Kinder- u. Jugendpsychiatrie

Dr. med. Adam Alfred
Kinder- u. Jugendpsychiater
Psychoanalyse für Erwachsene

Dr. med. Justina Hönes-Becker
Kinder- u. Jugendpsychiaterin
und -psychotherapeutin

Homöopathie, Neurofeedback

Nymphenburger Str. 156, 80634 München
Tel.: 089-189 512-10 / Fax: 089-189 512-13
sekretariat@praxis-alfred-becker.de
www.praxis-alfred-becker.de

Munich, ____________________

Patient regristration form for adults (self-payer)

Name:____________________ Surname:______________________ Date of birth:__________________

Adress: ____

____

Tel.:____________________________ Fax:___________________ Mobile:_________________________

E-Mail:____

Presenting problems:____

Initial-/follow-up appointment:____

As we are an order-only practice, we ask you to cancel in good time **(at least 24 hours in advance)** by fax, e-mail or telephone. We cannot rebook appointments cancelled at short notice and may have to charge you for them.

Please note, that the composition of Medical Certificates (for example Dyslexia, Dyscalculia, etc.) are charged additionally to the costs of the examination. Private insurances may cover these costs. According to the medical fee schedule GOÄ the costs can vary from 350€ to 500€ for a standard medical certificate (for example for the youth welfare apartment) and approx. 50€ for a medical statement, which is normally sufficient for schools. If in doubt, please ask for a cost estimate. Please note that the insurance refunds are restricted in some cases of psychiatric/psychological issues.
With your signature on the registration form, you declare that you are prepared to pay any premiums that insurance company may not be reimbursed by the insurance company.

Cost information for neurofeedback therapy: The billing is based on the GOÄ - number 886 analogously in the amount of 93.84€ per session. The appointments with Dr. Alfred regarding the therapy are additional.
Please pay the first invoice in the practice by EC card or cash against receipt.
Thereafter the invoice will be issued monthly.

____

Date, Signature

Gemeinschaftspraxis für Kinder- u. Jugendpsychiatrie

Dr. med. Adam Alfred
Kinder- u. Jugendpsychiater
Psychoanalyse für Erwachsene

Dr. med. Justina Hönes-Becker
Kinder- u. Jugendpsychiaterin
und -psychotherapeutin

Homöopathie, Neurofeedback

Nymphenburger Str. 156, 80634 München
Tel.: 089-189 512-10 / Fax: 089-189 512-13
sekretariat@praxis-alfred-becker.de
www.praxis-alfred-becker.de

Munich the________________

Medical history form for adults

Surname and Name:____

Age:______________________ Profession:____

Education:____

Learned profession:____

Symptoms:____

Why are you coming now? ____

____

____

What do you want to improve? ____

____

Current living situation:

Partnership: (please briefly describe current situation) _____________________________________

____

Children: (age, KiTa/school/study) ____

____

Work:____

____

Childhood/adolescence:

Were there any mental health-related problems in your childhood/adolescence, such as bedwetting, stuttering, anxiety, etc...?

____

____

Did you have any social problems (friends, bullying, etc.) as a child/adolescent?

____

____

Other stressful factors (moving, loss of caregivers, separation of parents, etc.):

____

____

Health:

Have you had any serious illnesses or even surgeries in your past life? If yes, please name them:

____

____

Do you take any medications regularly?____

How much alcohol do you drink on a daily basis?____

How many cigarettes do you smoke a day?____

Do you use any other drugs? Which ones?____

Have you ever had psychotherapy? When yes when?_______________________________________

____

Thank for your trust.

Gemeinschaftspraxis für Kinder- u. Jugendpsychiatrie

Dr. med. Adam Alfred
Kinder- u. Jugendpsychiater
Psychoanalyse für Erwachsene

Dr. med. Justina Hönes-Becker
Kinder- u. Jugendpsychiaterin
und -psychotherapeutin

Homöopathie, Neurofeedback

Nymphenburger Str. 156, 80634 München
Tel.: 089-189 512-10 / Fax: 089-189 512-13
sekretariat@praxis-alfred-becker.de
www.praxis-alfred-becker.de

Declaration of Consent for Adults

Surname, Name of the Patient:____ Date of Birth:__________________________

Adress:____

Please tick ❑ where applicable!

1. **Consent to communication with the practice**

I hereby consent to communication, if necessary also via **Email** (Note: we only send coded messages and attachments):

❑ YES, I consent ❑ NO, I dont consent

I hereby consent to communication, if necessary also via **SMS**:

❑ YES, I consent ❑ NO, I dont consent

I hereby consent to communication, if necessary also via **Fax:**

❑ YES, I consent ❑ NO, I dont consent

I hereby consent to communication, if necessary, also via **video:**

❑ YES, I consent ❑ NO, I dont consent

---

2. **Consent to postage of prescriptions**

I hereby consent to postage of prescriptions to my specified adress (if applicable also prescriptions under the Narcotics Act):

❑ YES, I consent ❑ NO, I dont consent

I hereby consent - if applicable and according to prior agreement - to postage of prescriptions to my specified pharmacy, via Post or via Fax:

❑ YES, I consent ❑ NO, I dont consent

For private insured patients only!

3. **Confidelity release and data protection statement of consent**

We have delegated invoicing for private insured patients to a medical billing company (Medas).

❑ I hereby release my dental, medical and/or therapeutic practitioner from their professional confidentiality duty for this and any future treatment and consent to the disclosure of all data required for billing purposes (name, address, date of birth, diagnoses, treatment data) to Medas factoring GmbH, Messerschmittstr. 4, 80992 Munich, Phone: 089 143 100 (hereinafter „Medas“). I am aware that the diagnoses and treatment data are sensitive person-related data as per Art. 9 of the German Data Protection Regulation (DSGVO). Medas acts as contract processor as per Art. 28 DSGVO. The practitioner controls the data protection as per Art. 4 No. 7 DSGVO. All data are handled confidentially and shall not be forwarded to third parties. The deletion of person-related data will ensue upon full contract completion and following the expiry of applicable retention terms. I consent to the transfer of the remuneration claims arising from my therapist‘s services to Medas for invoicing purposes through the latter. This declaration is voluntary and can be revoked at any time with future effect without giving reasons.

This consent is voluntary and can be revoked at any time with effect for the future without giving reasons. To do so, you can contact Medas at the above address.
You have the right at any time to request free information from Medas via the above contact details about your stored data, their correction or deletion as well as a restriction of processing. Medas is also happy to provide you with your data in a machine-readable format. If you have any questions about these rights, you can contact the Medas Data Protection Officer. The address is as follows: activeMind AG, Potsdamer Str. 3, 80802 Munich, E-Mail: datenschutz@medas.de. For data protection issues, you also have the right to lodge a complaint with a data protection supervisory authority.

____________________ ____________________

Date Signature Patient