

## 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](mailto:sekretariat@praxis-alfred-becker.de)

[www.praxis-alfred-becker.de](http://www.praxis-alfred-becker.de)

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Munich, \_\_\_\_\_

### Patient registration form for adults (self-payer)

name: \_\_\_\_\_ surname: \_\_\_\_\_ date of birth: \_\_\_\_\_

address: \_\_\_\_\_

tel.: \_\_\_\_\_ fax: \_\_\_\_\_ mobile: \_\_\_\_\_

mail: \_\_\_\_\_

reason for presenting: \_\_\_\_\_

initial-/follow-up appointment: \_\_\_\_\_

insurance:  private: \_\_\_\_\_ or  self-payer

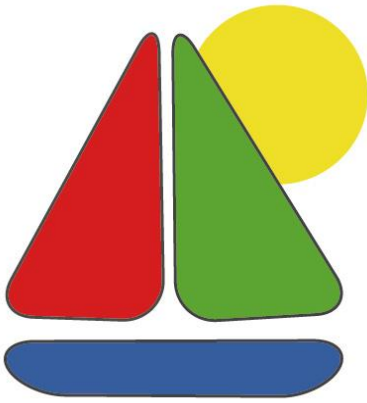
Invoices are issued monthly according to the GOÄ figures. Please refer to the cost estimate for the exact amount. We ask you to pay the invoice in the practice by EC card or cash against receipt.

Appointments can also be canceled at short notice in the event of illness, provided that a doctor's certificate is presented. Please understand that appointments can not be canceled for reasons other than illness. They will always be invoiced. This is because the appointment is only reserved for you and cannot be booked for another patient.

Please bring copies of test documents/doctor's letters (if available) with you to your appointment.

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date, signature of the patient



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**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? \_\_\_\_\_

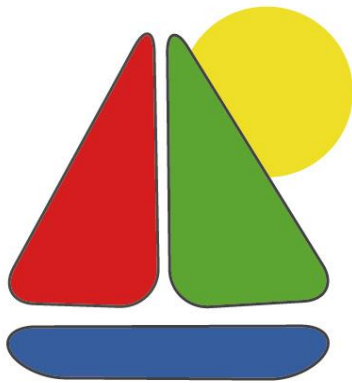
How much alcohol do you drink on a daily basis? \_\_\_\_\_

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.**



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### 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

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## 2. Consent to postage of prescriptions

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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

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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

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## **For private insured patients only!**

### 3. Confidility 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.

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Date

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Signature Patient