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:_____

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.

_____
date, signature of the patient

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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.

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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

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