Admission / Data privacy statement

CBT
Centrum für
Blutgerinnungsstörungen
und Transfusionsmedizin

Patient

Patient

Last Name, First Name | Date of Birth

Street Address

Postal code, City

Phone | Phone Office

Mobile

Health Insurance

Patients with private insurance

Last Name, First Name

Address (Please provide insurance owner, if different than address above)

Report

You will receive a letter with your laboratory results by post, as soon as they are available.

Consent to the transmission of the test results on the server operated by the RKI (Corona-Warn-App purposes).

I agree ☐ yes ☐ no

Data privacy statement

I took note of the data privacy statement with cross reference to the advice and complaint form of individual data, which can be found in the waiting area and on our homepage **www.cbtmed.de**.

X

city, date | signature patient/statutory representative

 www.cbtmed.de | info@cbtmed.de

COVID-19 Clinical questionnaire

CBT Centrum für Blutgerinnungsstörungen und Transfusionsmedizin

Has a test for COVID-19 already been carried out?	☐ no ☐ yes ☐ Swab (PCR) ☐ Antibody
 Testing after warning by "Corona-warn-App"	☐ no ☐ yes

Symptoms

☐ **yes**

If you are having symptoms, please specify which ones:

☐ **no** ▶ For patients who do not belong to one of the following groups, the detection of pathogenic SARS-Co2 virus will be conducted at one's own individual cost.

☐ severe respiratory disorders (e.g. acute bronchitis, pneumonia, shortness of breath, fever)

or

☐ change in sense of smell and taste

or

☐ symptoms after contact with a confirmed case of COVID-19 the health authorities must to be notified of any suspected cases

or

☐ deterioration in respiratory condition

or

☐ acute respiratory symptoms of all degrees (e.g. cough, sore throat, shortness of breath or rhinitis)

and

- belonging to risk group or
- occupation in care professions, in medical practice or hospital or
- after attending events without complying with current coronavirus regulations or
- contact with persons suffering from acute respiratory disorders (in domestic households or cluster of unexplained origin AND lasting for seven days with an incidence of >35/100.000 or
- contact with numerous persons while having symptoms or
- ongoing close contact with many people or hight-risk patients

How did you hear about us?

☐ Family doctor ☐ Internet ☐ local public health department

☐ Newspaper ☐ TV report ☐ friends / acquaintance

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Transfer of personal data
Consent form

Please paste patient label

Dear patient,

Subsequently to your examination at CBT you will receive a bill, if applicable.

To minimize administrative efforts, the liquidation is performed by ABV (society of physicians accounting – economic counselling – compensation systems GmbH, 45740 Mühlheim a.d. Ruhr, Obere Saarstraße 3 and 76255 Ettlingen, Weberstraße 55) in the name of CBT.

Therefore, ABV is your contact for issues concerning outstanding receivables. Due to of the cession of medical fees, CBT will only act as a witness in arguable processes. If there are any disagreements, you have to clarify them with ABV. However, the bill will be compiled following CBT instructions and will therefore constitute no additional costs.

To set up the bill, a transfer of your personal data (e. g. like address, date of birth, insurance company, dates of treatment, provided services and diagnoses) to ABV is necessary.

All information will be treated considering data safety regulations of the invoicing company. The company is under an obligation to ensure confidentiality and will treat any information confident and use them only for billing and collection purposes.

Hints about costs and absorption of costs

You are obligated to pay the examination bill, if your health insurance does not cover the costs of your treatment and other provided services.

The cost for the diagnosis of SARS-CoV-2 antibodies amounts to 30.37€.

The cost for the direct verification of SARS-CoV-2 via PCR amounts to 75.-€.

With your signature, you agree with this procedure of settlement and the cession of medical fees to ABV for all following medical treatments by us until revocation.

I agree with the procedure of settlement.

I am informed about my right of written revocation at any time for future administration according to art. 7 GDPR.

city, date

X

signature patient/statutory representative

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