Agreement and consent for SARS-CoV-2 testing

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_____
(surname, first name)

_____
(address)

E-Mail: Phone:

I am an insured person and, at my express request, wish to have the following medical services performed.
I have been informed in particular that the services go beyond the scope of general care and that I am therefore obliged to pay for the medical services listed below privately, i.e. independently, in accordance with the German Scale of Fees for Physicians (GOÄ) and that reimbursement of the costs by reimbursement agencies cannot be guaranteed, or not to the full extent.
The smear test is performed using the reference method from the Robert Koch Institute (RT-PCR). The antibody rapid test is performed by venous blood sampling.

I am aware that a negative result does not necessarily exclude a fresh infection. This test is therefore only a snapshot for the time of testing.
I am further informed that - as soon as this test is positive - the positive test result must be reported immediately to the public health department.

☐	Selection	Costs	Signature
☐	PCR testing 24h	49,59 €	
☐	Antibody testing	24,30 €	
☐	Antigen rapid test	22,12 €	

You will receive confirmation of payment by mail / SMS. A detailed invoice will follow by mail.

Date/Signature Patient_____ Date/Signature Doctor_____

Ärztehaus Mitte

Consent to data protection

I hereby consent,

Name, first name:_____

Address:_____

Date of birth:_____

E-mail / Phone:_____

a, in the patient information to the DSGVO explained collection, processing and passing on of my data as well as my health data for the purpose of the treatment and account (after §630a Abs. 1 BGB) and explain me in agreement that

- the MVZ Ärztehaus Mitte may request treatment data and findings concerning me from other physicians and service providers (e.g. psychotherapists, hospitals, pharmacies, nursing services, physiotherapists, cooperating laboratories, etc.) for the purpose of information, further treatment and documentation.
- the MVZ Ärztehaus Mitte transmits treatment data, samples taken and findings concerning me to other doctors and service providers treating me.
- my examination/treatment documents are used by all physicians working at the MVZ.
- in the event of a change of doctor, my previous general practitioner will send the documents stored about me to my new general practitioner or my new general practitioner will request these documents from a previous general practitioner.
- my doctor can remind me of treatment appointments (e.g. early detection examinations, vaccinations).

I am informed that without my consent, treatment can only take place to a limited extent, if at all. I am aware that I can revoke this declaration of consent at any time verbally or in writing to the practice.

Date, signature _____