## 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.**

| X | Selection | Costs | Signature |
|---|---|---|---|
| ☐ | PCR testing 24h | 74,37 € | |
| ☐ | Antibody testing | 35,02 € | |

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 agree,

Name, first name: _____

Address: _____

Date of birth: _____

E-Mail: _____

Phone: _____

I consent to the collection, processing and transfer of my data as well as my health data for the purpose of treatment and billing as explained in the patient information on the GDPR (according to §630a para. 1 BGB) and declare my consent that

- the MVZ Ärztehaus Mitte requests 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, also in unencrypted e-mails (§87a).
- my examination/treatment documents are used by all physicians working in the MVZ and the MVZ - in accordance with the legal storage regulations - stores documents of my examination/treatment documents (such as this form) exclusively in digital form and hands over the corresponding originals to me.
- in the event of a change of physician- my previous primary care physician transmits the documents stored about me to my new primary care physician or my new primary care physician requests these documents from my previous primary care physician.
- my doctor is allowed to remind me of treatment appointments.
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I am informed that without my consent, treatment can only be carried out to a limited extent or, if necessary, not 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 _____