TFP Kinderwunsch Düsseldorf

REQUIRED DOCUMENTATION

Please complete the enclosed documents and send them to us before your interview via E-mail to duesseldorf@tfp-fertility.com.

PLEASE SEND US THE FOLLOWING DOCUMENTS BEFORE YOUR FIRST INTERVIEW	
☐	Admission information new patient pair
☐	Info on data protection and declaration of consent for the use of contact data
☐	medical history sheet
☐	Declaration of consent to the exchange of information with third parties
☐	Patient information on preventive health care infertility
☐	Declaration of consent for benefit accounting
☐	Declaration of consent for the disclosure of pseudonymised treatment data
☐	Patient education SARS-CoV-2 & hygiene measures

IMPORTANT: We must receive the documents at least two days before the interview, otherwise we reserve the right to cancel the appointment.

PLEASE ALSO BRING THE FOLLOWING DOCUMENTS WITH YOU TO YOUR APPOINTMENT:	
☐	Insurance card - if your appointment is a couple's appointment, please have both partners present.
☐	All existing findings and treatment records
☐	Vaccination card patient

If you have any questions, please feel free to contact us at any time on +49 (0) 211-90197-0 or by e-mail at duesseldorf@tfp-fertility.com.

If you are unable to keep your appointment, please inform us as soon as possible so that we can reduce the waiting time for our patients to a minimum.

We thank you for your trust in TFP Kinderwunsch Düsseldorf and look forward to seeing you!

Your practice team

TFP Kinderwunsch Düsseldorf

ADMISSION INFORMATION NEW PATIENT PAIR

PERSONAL DETAILS WOMAN
Name:
Prename:
Date of birth:
Patient-ID:
Profession:

PERSONAL DETAILS MAN
Name:
Prename:
Date of birth:
Patient-ID:
Profession:

ADDRESS / CONTACT DETAILS WOMAN
Street and no.:
postcode:
Residence:
Landline number:
Mobile / Handy:
E-Mail-Address:

ADDRESS / CONTACT DETAILS MAN
Street and no.:
postcode:
Residence:
Landline number:
Mobile / Handy:
E-Mail-Address:

HEALTH INSURANCE
Type of insurance: ☐ statutory ☐ private
Health insurance:
insurance number:

HEALTH INSURANCE
Type of insurance: ☐ statutory ☐ private
Health insurance:
insurance number:

PARTNERSHIP INFORMATION
☐ We hereby declare that we are married to each other.
☐ We live in a partnership built to last.

DATE, SIGNATURE WOMAN	DATE, SIGNATURE MAN

TFP Kinderwunsch Düsseldorf

INFO ON DATA PROTECTION AND DECLARATION OF CONSENT FOR THE USE OF CONTACT DATA

PERSONAL DETAILS WOMAN	PERSONAL DETAILS MAN
Name:	Name:
Prename:	Prename:
Date of birth:	Date of birth:

When protecting your personal data, the TFP Group applies the highest standards in accordance with European and German data protection laws. Your medical data will only be used in the context of your medical treatment.

Any additional consent you give in the course of your treatment at TFP can be revoked at any time. A revocation has no effect on previously processed data or on your treatment itself. Please let us know if we have collected data incorrectly. We will delete any unlawfully collected data immediately.

You can obtain information about which data we have stored about you at any time. The duration of the storage corresponds to the respective retention obligations. We will be happy to provide you with more detailed information about this. You also have the right to lodge a complaint with the state data protection authority at any time.

As TFP Kinderwunsch Düsseldorf, we attach great importance to excellent patient service. An important part of this service is being able to contact you easily and at short notice. Therefore, we ask you for the following consents.

WE HEREBY AGREE TO	
☐	that TFP Kinderwunsch Düsseldorf reminds us of agreed appointments by SMS via the mobile phone number provided.
☐	that the TFP Kinderwunsch Düsseldorf reminds us of agreed appointments via the e-mail address provided
☐	that the TFP Kinderwunsch Düsseldorf sends us the information accompanying the care and treatment by SMS to the mobile number provided.
☐	that the TFP Kinderwunsch Düsseldorf sends us information accompanying the care and treatment to the e-mail address provided.
☐	that TFP Kinderwunsch Düsseldorf or TFP Fertility Germany may contact us via the e-mail provided for the purpose of their own quality assurance.
☐	that the TFP Kinderwunsch Düsseldorf or TFP Fertility Germany sends us a monthly newsletter by e-mail. The newsletter contains reports on interesting developments in fertility medicine and from the TFP Fertility Centres.

You can revoke these consent forms at any time, either individually or as a whole. Simply send a message to this effect by e-mail to duesseldorf@tfp-fertiliy.com or by post to the Kinderwunsch-zentrum.

Your personal data will of course be treated confidentially in accordance with the requirements of the Data Protection Act.

With your signature you confirm the data protection information and the use of your contact data.

Thank you for your trust!

DATE, SIGNATURE WOMAN	DATE, SIGNATURE MAN

TFP Kinderwunsch Düsseldorf

ANAMNESIS WOMAN

PERSONAL DETAILS WOMAN

Name:

Prename:

Date of birth:

Patient-ID:

DISEASES

Underlying diseases
(e.g. high blood pressure, thyroid disease):

Operations (type and year of operation):

Fallopian tubes tested for patency (if yes, when and how?):

Endometriosis known (in the family or with you):

☐ yes ☐ no

Thromboses (in the family or with you):

Genetic diseases (in the familiy or with you):

CHILD WISH

Desire to have children since:

Children or conceived pregnancies
(e.g. 2010, birth of healthy boy or 2011 miscarriage):

☐ In current partnership ☐ In another partnership

Infertility treatment that has already taken place
(e.g. stimulation at the gynaecologist, 2009 2x IVF):

CYCLE

First menstrual period with _____ years.

Cycle length (e.g. 26 - 28 days):

Bleeding duration (e.g. 4 - 5 days):

Bleeding intensity (e.g. light, medium, heavy, very heavy):

Menstrual pain: ☐ yes ☐ no

Last period (first day):

MEDICAL AMENTS

Regular medication
(Preparation and dosage, p.e. Femibion 1 / day):

Drug allergy (if yes, which ones?):

Other allergies:

OTHER DISCLOSURES

Smoking ☐ yes ☐ no

Alcohol ☐ yes ☐ no

Body size (cm): Body weight (kg):

DATE, SIGNATURE WOMAN

TFP Kinderwunsch Düsseldorf

ANAMNESIS MAN

PERSONAL DETAILS MAN

Name:

Prename:

Date of birth:

Patient-ID:

DISEASES

Underlying diseases
(e.g. high blood pressure, thyroid disease):

Operations (type and year of operation):

Undescended testicles in childhood (yes / no):

Has a spermiogram already been performed?
(yes / no, if yes, when?):

Genetic diseases (in the familiy or with you):

CHILD WISH

Children or conceived pregnancies
(e.g. 2010, birth of healthy boy or 2011 miscarriage):

☐ In current partnership ☐ In another partnership

Infertility treatment that has already taken place
(e.g. stimulation at the gynaecologist, 2009 2x IVF):

MEDICAL AMENTS

Regular medication
(Preparation and dosage, p.e. Femibion 1 / day):

Drug allergy (if yes, which ones?):

Other allergies:

OTHER DISCLOSURES

Smoking	☐	yes	☐	no
Alcohol	☐	yes	☐	no

Body size (cm): Body weight (kg):

DATE, SIGNAURE MAN

TFP
Kinderwunsch Düsseldorf

DECLARATION OF CONSENT TO THE EXCHANGE OF INFORMATION WITH THIRD PARTIES

PERSONAL DETAILS WOMAN	PERSONAL DETAILS MAN
Name:	Name:
Prename:	Prename:
Date of birth:	Date of birth:
Patient-ID:	Patient-ID:

REQUEST / TRANSMISSION OF PATIENT FILES

We hereby give our consent for the practice findings to be obtained from the following service providers and for findings obtained from me to be transmitted to service providers who also treat me.

GYNAECOLOGIST	GP / UROLOGIST
Ms. / Mr. Dr. med.:	MS. / Mr. Dr. med.:
Street, No.:	Street, No.:
postcode:	Postcode:
Residence:	Residence:
Tel. number:	Tel. number:
Fax-number.:	Fax-number.:

TRANSMISSION OF INFORMATION TO THIRD PARTIES (e.g. FURTHER PRACTITIONERS, MEMBERS, INTERPRETERS)

We agree that information may be passed on to the following persons, provided that their identity has been established. This also applies to telephone enquiries.

PERSON 1	PERSON 2
Ms. / Mr.:	Ms. / Mr.:
Street, No.:	Street, No.:
PLZ:	PLZ:
Residence:	Residence:
Tel. number:	Tel. number:
Fax-No.:	Fax-No.:

I can revoke this declaration of consent in writing at any time. In the case of incorrectly collected data, I have the right to have it corrected or deleted after being informed. I have the right to obtain information about the data stored about me at any time. I also have the right to lodge a complaint with the state data protection authority at any time.

DATE, SIGNATURE WOMAN	DATE, SIGNATURE MAN

PATIENT INFORMATION HEALTH CARE DESIRE FOR CHILDREN

PERSONAL DETAILS WOMAN

Name:	Prename:
Date of birth:	Patient-ID:

VERIFICATION OF THE VACCINATION STATUS

Before a planned pregnancy, the woman should have her vaccination status checked. This applies in particular to vaccination protection against rubella and chickenpox (varicella) infections or infection with pertussis (B. pertussis).

In case of a lack of protection, vaccination is strongly recommended before starting fertility treatment, as infections during pregnancy can cause severe health damage to the child. The vaccination can generally be carried out by your referring gynaecologist or family doctor. Proof of vaccination must be provided in writing in the form of the vaccination record. As the rubella and varicella vaccination is carried out with a live vaccine, no pregnancy should occur in the next 1-2 months after the vaccination.

Vaccination recommendation

- ☐ Rubella
- ☐ B. pertussis
- ☐ Varicella

Consent to vaccination recommendation

- ☐ I have read and understood the vaccination recommendation
- ☐ Vaccination refused despite explicit instruction

FOLIC ACID INTAKE TO AVOID A NEURAL TUBE DEFECT

In the first 28 days after fertilisation of the human egg, the neural tube closes in 999 out of 1,000 embryos.

embryos the neural tube closes. The spinal cord later forms from the neural tube. Provided there are no other developmental disorders, these will be healthy children. In one in 1,000 embryos, however, the end of this neural tube is missing - with fatal consequences.

Neural tube defects affect about 800 children per year in Germany. The diagnosis is usually made prenatally. In about 500 of these children, the parents decide to terminate the pregnancy in order to spare the children a life with severe disabilities. This is a difficult decision for the parents concerned, as the diagnosis can almost always only be made in the second third of the pregnancy, i.e. at a time when the mother may already have felt the first movements of the child.

About half of the cases occurring in Germany per year could be prevented. Numerous international studies have shown that an additional intake of folic acid around the time of conception, starting 4-6 weeks before pregnancy, can reduce the risk of neural tube defects. You can get advice on the various preparations (e.g. Folio, Folioforte, Feminion) at your pharmacy.

DATE, SIGNATURE WOMAN

TFP
Kinderwunsch Düsseldorf

DECLARATION OF CONSENT FOR THE BILLING OF SERVICES FOR PERSONS WITH STATUTORY HEALTH INSURANCE

PERSONAL DETAILS WOMAN	PERSONAL DETAILS MAN
Name:	Name:
Prename:	Prename:
Date of birth:	Date of birth:

I have been informed that the statutory health insurance companies only partially cover or do not cover some services within the framework of fertility treatment.

I have been informed that these services will be invoiced in accordance with GOÄ (Gebührenordnung für Ärzte, in der jeweils gültigen Fassung) and that services provided by TFP Sperm Bank Germany GmbH will be invoiced privately.

§ 4 Abs. 5 (GOÄ)
If services are provided by third parties (e.g. anaesthesia, laboratory, cytology), you will receive a separate invoice from this institution..

I undertake to pay the 50% co-payment of a treatment according to § 27a SGB V (see 1.) or the fee calculated according to the GOÄ (taking into account the maximum rates § 5 GOÄ) (see 2., 3. and 4.) myself after appropriate prior information.

According to § 12 GOÄ, the invoice is due immediately upon receipt. It is possible to inspect a list of services according to GOÄ at your attending physician's office.

One of the prerequisites for carrying out fertility treatment is an HIV test as part of an infection screening, which must be repeated at certain intervals.
I hereby give my consent in principle to MVZ TFP Düsseldorf GmbH to carry out the necessary HIV examinations.

Data transmission to private medical clearing house
Please note that the MVZ TFP Kinderwunschzentrum Düsseldorf has commissioned the Deutsche Gesellschaft für privatärztliche Abrechnung (DGPar) with the billing. Billing is therefore carried out by the DGPar.
With my signature I confirm that I have taken note of this information and undertake to pay the fees incurred accordingly.

Consent pursuant to Article 6 (1a) DSGVO for the transfer of data to the DGPar.

☑ I also agree that all necessary documents, including the service numbers and the treatment documentation as well as all documents required for billing, may be passed on to the DGPar for the preparation of the invoice as well as for the collection of any necessary claims.
In this respect, I expressly release the attending physician from his medical confidentiality obligation (§ 203 StGB).

I can revoke this declaration of consent in writing at any time. In the case of incorrectly collected data, I have the right to have it corrected or deleted after informing the practice. I have the right to obtain information about the data stored about me at any time. I also have the right to lodge a complaint with the state data protection authority at any time.

DATE, SIGNATURE WOMAN	DATE, SIGNATURE MAN

INFORMATION ON THE INVOICING OF SERVICES FOR STATUTORY HEALTH INSURERS

INTERVIEWS AND PRELIMINARY EXAMINATIONS (DIAGNOSTICS)

All services listed in the catalogue of services provided by the statutory health insurance funds (GKV) are billed directly to your health insurance fund via your health insurance card. This includes, for example, the initial consultation, ultrasound and blood tests as part of the diagnosis and the discussion of the findings. The blood tests for HIV, hepatitis B (HBs-AG, HBc), hepatitis C (HBC), rubella and whooping cough (pertussis) are sometimes excluded. Only when it has been decided which treatment is to be carried out on you, can costs be incurred in the preparation and implementation of fertility treatment which are not covered by the statutory health insurance funds. We will invoice you privately for these services after providing you with preliminary information. After a treatment cycle, we will then bill your health insurance company directly for the pregnancy test and the other services until the start of a new treatment cycle via your health insurance card.

In the following, we inform you about the services that are not included in the catalogue of services of the statutory health insurance funds and are therefore invoiced privately:

BEFORE STARTING TREATMENT

Already in the run-up to fertility treatment it is necessary to carry out certain blood tests. A prerequisite for fertility treatment in our practice - especially for the protection of the child - are certain infection screening examinations. These examinations, some of which have to be repeated at certain intervals, currently concern: HIV, hepatitis B (HBs-Ag and HBc), hepatitis C (HCV), and possibly rubella and whooping cough (pertussis). The above-mentioned examinations are only partly covered by the statutory health insurance and must be invoiced to you privately according to the GOÄ (medical fee schedule). You can find out the costs for this from your attending doctor.

DURING THE TREATMENT

The guidelines on artificial insemination are fulfilled
The services of a treatment approved by the statutory health insurance (signed treatment application) according to § 27a SGB V (Social Code Book V) are covered to 50% by the statutory health insurance and invoiced directly to them. The 50% co-payment will be invoiced to you by the practice.

The guidelines on artificial insemination are not fulfilled (e.g. age limits).
If you do not meet the requirements for health insurance billing, we will have to bill you for the entire treatment privately according to the GOÄ (scale of fees for doctors).

Optional services
These are services that are not included in the catalogue of services provided by the statutory health insurance funds (e.g. freezing and storage of germ cells). These services will be invoiced to you privately by MVZ TFP Düsseldorf GmbH according to GOÄ (scale of fees for doctors).

Treatment cycles with donor sperm
Treatments with donor sperm are not included in the benefits catalogue of the statutory health insurance funds. They will be invoiced to you privately by MVZ TFP Düsseldorf GmbH according to GOÄ (scale of fees for doctors). Certain special services in the context of artificial insemination with donor sperm are provided by our TFP Sperm Bank Germany GmbH and are then also invoiced by them.

After notification by your attending physician of the necessary private billing of certain services (e.g. in cases 2., 3. and 4.), you will receive a cost estimate for the planned treatment / cost information on supplementary and additional methods. Should you interrupt the treatment in the meantime and continue it at a later point in time, this treatment information continues to be valid and can only be declared invalid in writing.

DECLARATION OF CONSENT TO PRIVATE LIQUIDATION FOR PRIVATE PATIENTS

PERSONAL DETAILS WOMAN	PERSONAL DETAILS MAN
Name:	Name:
Prename:	Prename:
Date of birth:	Date of birth:

I hereby apply for treatment and invoicing according to GOÄ (Gebührenordnung für Ärzte, in the currently valid version) by the doctors of MVZ TFP Düsseldorf GmbH for the period of my treatment. Should I interrupt the treatment in the meantime and continue it at a later date, this treatment contract remains valid and can only be declared invalid in writing.

I declare my agreement with the liquidation according to GOÄ (scale of fees for physicians).

§ 4 Abs. 5 (GOÄ)

If services are provided by third parties (e.g. anaesthesia, laboratory, cytology), you will receive a separate invoice from this institution.

I undertake to pay the fee calculated according to the GOÄ (taking into account the maximum rates § 5 GOÄ) myself, insofar as insurance companies and/or subsidy agencies do not cover it or do not cover it in full.

According to § 12 GOÄ, the invoice is due immediately upon receipt. You can inspect the GOÄ at your attending physician's office.

One of the prerequisites for carrying out fertility treatment is an HIV test as part of an infection screening, which must be repeated at certain intervals. I hereby give my consent in principle to MVZ TFP Düsseldorf GmbH to carry out the necessary HIV examinations.

Data transmission to private medical clearing house

Please note that the MVZ TFP Kinderwunschzentrum Düsseldorf has commissioned the Deutsche Gesellschaft für privatärztliche Abrechnung (DGPar) with the billing. Billing is therefore carried out by the DGPar.

With my signature I confirm that I have taken note of this information and undertake to pay the fees incurred accordingly.

Consent pursuant to Article 6 (1a) DSGVO for the transfer of data to the DGPar

☑ I also agree that all necessary documents, including the service numbers and the treatment documentation as well as all documents required for billing, may be passed on to DGPar for the preparation of the invoice as well as for the collection of any necessary claims.

In this respect, I expressly release the attending physician from his medical confidentiality obligation (§ 203 StGB).

I can revoke this declaration of consent in writing at any time. In the case of incorrectly collected data, I have the right to have it corrected or deleted after informing the practice. I have the right to obtain information about the data stored about me at any time. I also have the right to lodge a complaint with the state data protection authority at any time.

DATE, SIGNATURE WOMAN	DATE, SIGNATURE MAN

TFP Kinderwunsch Düsseldorf

DECLARATION OF CONSENT FOR THE TRANSFER OF PSEUDONYMISED TREATMENT DATA

PERSONAL DETAILS WOMAN	PERSONAL DETAILS MAN
Birthname:	Birthname:
Birthplace:	Birthplace:
Date of birth:	Date of birth:

Dear patient couple,

As part of the legally required quality assurance, in addition to reporting to the German IVF Register (DIR), a nationwide annual submission of treatment data to the Working Group on Quality Assurance in Reproductive Medicine (QS-Repromed) has been mandatory for all fertility centres in Germany since 2014.

In reproductive medicine, the medical associations of the federal states are responsible for the licensing of reproductive medicine centres and at the same time for monitoring the quality of treatment as part of their statutory mandate in accordance with §121a of the German Social Code, Book V.

The prerequisite for the performance of your examination and treatment at the TFP MVZ Düsseldorf is therefore the legally required transfer of your data to QS-Repromed and the DIR.

The transmission is pseudonymised. This means that your data is transmitted and managed under a patient identification number.

To generate the patient identification number, your date of birth, place of birth and name at birth are required.

The pseudonymisation, allows QS-Repromed and DIR to make requests to the treating facility of the TFP and your treatment data can be checked within the scope of this. The transmission of pseudonymised treatment data contributes significantly to quality assurance.

The consent to the transmission of pseudonymised treatment data can be withdrawn at any time by means of a written declaration of revocation. In this case, only anonymised treatment data will be transmitted to QS-Repromed/DIR. This data is only used for legally obligatory reporting. Statistical evaluations are also in the interest of the patient.

If no therapy is carried out, no data is passed on. The disclosure is bound to the requirements of the Data Protection Act (according to § 4 paragraph 1 and § 4a). For this reason, it is necessary that you consent to the disclosure and that you are granted a subsequent right of objection.

With my signature I confirm that I have been informed about the right of withdrawal and agree to the transfer of pseudonymised treatment data for quality assurance purposes.

DATE, SIGNATURE WOMAN	DATE, SIGNATURE MAN

Information pursuant to Art. 13 DSGVO on the transfer of data to the DIR

1. Name and contact details of the responsible persons and, if applicable, data protection officers

The persons independently responsible within the meaning of the German Federal Data Protection Act (BDSG), the European Data Protection Regulation (DSGVO) and other national data protection laws of the member states as well as other data protection regulations are:

Deutsches IVF-Register e.V. (D·I·R)®

The current Board of Directors is responsible

Office: Lise-Meitner-Straße 14, D-40591 Düsseldorf

Tel: +49 (0)211 913 848 00; Fax: +49 (0)211 913 848 01; E-Mail: geschaeftsstelle@deutsches-ivf-register.de

Data Protection Officer: AMD TÜV Rheinland, christophe.kabambe@de.tuv.com

Data protection supervisory authority: State Commissioner for Data Protection and Freedom of Information of North Rhine-Westphalia, P.O. Box 20 04 44, D-40102 Düsseldorf, Tel: +49 (0)2 11 384 24-0; Fax: +49 (0) 2 11 384 24-10; E-Mail: poststelle@ldi.nrw.de

FertiPROTEKT Netzwerk e.V.

The current Board of Directors is responsible

Office: Weißdornweg 17, D-35041 Marburg/Lahn

Tel.: +49 (0) 64 20 305 05 83; E-Mail: info@fertiprotekt.com

Data protection supervisory authority: The Hessian Data Protection Commissioner, Postfach 31 63, D-65021 Wiesbaden

Tel.: +49 (0)6 11 140 80; Fax: +49 (0) 6 11 14 08-900; E-Mail: poststelle@datenschutz.hessen.de

Medical Association Schleswig-Holstein

Präsident (Verantwortlicher): Prof. Dr. med. Henrik Herrmann

Bismarckallee 8 – 12, D-23795 Bad Segeberg

Tel: +49 (0) 4551 803 0; Fax: +49 (0) 4551 803 101; E-Mail: info@aeksh.de

Data Protection Officer: Tel: +49 (0) 4551 803 251; E-Mail: datenschutzbeauftragte@aksh.de

Data protection supervisory authority: Schleswig-Holstein State Commissioner for Data Protection, P.O. Box 71 16, D-24171 Kiel, Tel.: +49 (0) 4 31 988-1200; Telefax: +49 (0)4 31 988-1223; E-Mail: mail@datenschutzzentrum.de

2. Purposes and legal bases of data processing

Your data is processed for the purpose of scientific and statistical collection and evaluation of data for tracking the development of human reproductive medicine in Germany.

The legal basis for data processing results from the requirements of the Sperm Donor Register Act and the requirements for pre-implantation diagnostics (§3a Embryo Protection Act). A further legal basis is the legitimate and overriding interest (Art. 6 para. 1 p. 1 lit. f DSGVO) of the general public in improving health care and gaining scientific knowledge. If the aforementioned legal bases are not relevant, the processing is based on your consent.

3. Duration of storage The data collected from you will be deleted or blocked as soon as the purpose of the processing no longer applies and the deletion does not conflict with any statutory retention obligations.

4. Right of revocation You can revoke your consent at any time with effect for the future. The revocation has the consequence that data processing for the aforementioned purposes can no longer take place.

5. Data subject rights According to Art. 12 GDPR, you have the right to information according to Art. 15 GDPR, the right to rectification according to Art. 16 GDPR, the right to erasure according to Art. 17 GDPR, the right to restriction of processing according to Art. 18 GDPR, the right to data portability from Art. 20 GDPR and the right

to object according to Art. 21 GDPR. The restrictions according to the regulations of §§34 and 35 BDSG-Neu apply to the right to information and the right to deletion. In addition, you have the right to lodge a complaint with a data protection supervisory authority pursuant to Art. 77 DSGVO. You can contact a supervisory authority in the member state of your usual place of residence, your place of work or the place of the alleged infringement at any time.

6. Right of objection If your personal data is processed on the basis of legitimate interests pursuant to Art. 6 (1) p. 1 lit. f DSGVO, you have the right to object to this pursuant to Art. 21 DSGVO, insofar as there are grounds for doing so that arise from your particular situation.

PATIENT PROCESSING SARS-CoV-2 & HYGIENE MEASURES

PERSONAL DETAILS WOMAN	**PERSONAL DETAILS MAN**
Name:	Name:
Prename:	Prename:
Date of birth:	Date of birth:

Under the following link you will find a detailed explanation of the risks of infection:

RKI - Coronavirus SARS-CoV-2 - Epidemiologischer Steckbrief zu SARS-CoV-2 und COVID-19

I hereby declare that I have been informed in detail about the risks of infection with SARS-CoV-2 and the effects on the fertility treatment and that I expressly wish to undergo the treatment.

I know that fertility treatment is only possible under strict safety conditions, which I will fully comply with. The aim here is to avoid infection in myself, other patients and the clinic staff.

The hygiene requirements also apply to patients who are only in our practice for individual medical services, such as spermiograms.

The following precautions must be taken:

- Wearing a mouth and nose protector
- Keeping a minimum distance of 1.5 m from the nearest person
- The person to be treated comes to the appointment unaccompanied, with the exception of the follicle puncture/ovum collection.
- Payment is only possible by bank transfer. Only in absolutely exceptional cases is cash payment possible at the administration office.

In case of fever, cough and other COVID or cold symptoms, I agree not to enter the clinic and to adjust or discontinue the therapy accordingly after consultation with the attending doctor.

We also ask you to inform us by telephone if you experience cold symptoms within a week after your appointment with us (consultation, ultrasound check and especially after follicle puncture or embryo transfer).

DATE, SIGNATURE WOMAN	**DATE, SIGNATURE MAN**

DIRECTIONS - HOW TO GET TO US COMFORTABLY!

ARRIVAL BY CAR

Parking lots are located in the underground garage.