TFP Fertility Wels, Traunufer Arkade 1, 4600 Thalheim bei Wels

YOUR WELCOME FOLDER

Thank you very much for your registration for the first interview at the TFP Fertility Wels. We look forward to accompanying you on your way to your desired child.

Our experienced team of doctors and embryologists will be happy to assist you. Our team works according to the highest international standards and treatment methods, and we take the time to tailor the consultation and treatment to your personal needs.

If you are unable to attend your appointment, we ask you to inform us as soon as possible so that we can reduce the waiting time for our patients to a minimum. If you cancel your registration up to 7 days before the first appointment, this can be done free of charge without a cancellation fee. Cancellation within the last 7 days before the appointment will incur a cancellation fee of 50% of the call fee. In case of non-appearance and without cancellation 100 % of the call fee will be charged as cancellation fee.

To prepare your first meeting, we will send you our welcome folder with important information and documents.

Please complete the enclosed documents and return them to us by e-mail to wels@tfp-fertility.com at least seven days before your meeting.

REQUIRED DOCUMENTS

PLEASE SEND US THE FOLLOWING DOCUMENTS BEFORE YOUR FIRST CONSULTATION

- New patient survey
- Admission information new patient pair
- Anamnesis sheet (woman and man)
- Declaration of consent for the use of e-mail and texts (SMS)
- If available findings and treatment documents:
  - Blood results of the woman
    - Current hormon status (not older than six months): basal hormones (between 3-8 days of cycle): FSH, LH, E2, Prog, bTSH, PRL, AMH
    - If available: TEST, DHEA-S, Vit. D
  - Woman's cancer test (PAP test): not older than one year (after conisation, not older than six months)
  - Spermiogramm – not older than one year
  - If available: Chromosome examination (examination of the blood for disorders in the genetic material/genetics) and/or further genetic analysis results.

PLEASE ALSO BRING THE FOLLOWING DOCUMENTS WITH YOU TO YOUR APPOINTMENT

- Copies of photo IDs
- Marriage certificate (if available)
- All existing surgical findings or findings from preliminary tests in other IVF clinics

If you have any questions, please do not hesitate to contact us between 08:00 and 16:00 hrs on +43 (0) 7242 22 44 66 or by e-mail at wels@tfp-fertility.com.

We thank you for your confidence in the TFP Fertility Wels and look forward to hearing from you!
Your practice team

INFORMATION AND CONSENT TO DATA PROTECTION WITHIN TFP

PERSONAL DATA WOMAN	PERSONAL DATA MAN
Last Name:	Last Name:
First Name:	First Name:
Date of Birth:	Date of Birth:

We are pleased that you have decided to have medical consultations/treatments at the TFP Fertility Wels, which is part of the TFP Fertility Group.

Due to the new data protection legislation according to the European Data Protection Regulation (DSGVO), we would like to inform you that the TFP Group sets the highest standards for the protection of your personal data according to the European and Austrian data protection laws. We would like to confirm once again that your medical data will only be used for your medical treatment within the scope of the treatment contract.

In order to optimise the processes necessary for the billing of medical services within the TFP Group for the benefit of the patients, your personal data (e.g. name, address, contact data, insurance number and carrier) as well as your medical data (e.g. treatment and billing data) - insofar as these are required for a central billing of services within the TFP Group - are also accessible to qualified employees of the TFP Group at other locations in Austria.

All employees or service providers that we entrust with the processing of your data in this sense are obligated to the same standards.

You have the right to revoke any consent that you give to TFP in the course of your treatment, e.g. for the purpose of receiving e-mails accompanying treatment or a newsletter or for the purpose of participating in our quality assurance and satisfaction surveys (electronic, postal or telephone) after treatment. A revocation has no effect on previously processed data or on your treatment per se. Please inform us if we have collected your data incorrectly so that we can correct it. We will delete unlawfully collected data immediately.

You can obtain information at any time as to which data we have stored about you. The duration of the storage corresponds to the respective storage obligations. We will be happy to provide you with further information. You also have the right to file a complaint with the data protection authority at any time. Further information on data protection and the current locations of the TFP Group can be found on our website at https://tfp-fertility.com/de-at/datenschutz.

Thank you very much for your trust!

With your signature you confirm that you have taken note of this data protection information and that you agree with the processing of your data as described for the proper handling of the treatment contract.

DATE, SIGNATURE WOMAN	DATE, SIGNATURE MAN

TFP Fertility Wels

NEW PATIENT SURVEY

PERSONAL DATA WOMAN	
Last Name:	First Name:
Date of Birth:	

We are looking forward to welcoming you soon to the TFP Fertility Wels. In order to improve our service continuously, we kindly ask you to answer the following questions. Of course, your data will be treated confidentially during the medical treatment.

Please tick for the gynaecologist (for the woman) and urologist (for the man) treating you whether they

	GYNAECOLOGIST	UROLOGIST
recommended us	☐	☐
Which other centre was recommended to you?		
did not recommend us	☐	☐
did not recommended a child	☐	☐

HOW DID YOU HEAR ABOUT US

- ☐ By referring gynaecologists
- ☐ By other doctor (name, place, specialist):
- ☐ Via our homepage
- ☐ By former patients
- ☐ By recommendation of third
- ☐ Media reports
- ☐ Internet forums
- ☐ Facebook / YouTube
- ☐ Business cards or other material in other medical practices
- ☐ Other:

TFP Fertility Wels

ADMISSION INFORMATION NEW PATIENT COUPLE

Your first consultation on:

PERSONAL DATA WOMAN
Title and Last Name:
First Name:
Maiden Name:
Date of Birth:
Nationality:

PERSONAL DATA MAN
Title and Last Name:
First Name:
Maiden Name:
Date of Birth:
Nationality:

ADDRESS / CONTACT DATA WOMAN
Street & No.:
Post Code and City:
Country:
Landline:
Mobile Phone:
E-mail address:
Skypename:

ADDRESS / CONTACT DATA MAN
Street & No.:
Post Code and City:
Country:
Landline:
Mobile Phone:
E-mail address:
Skypename:

INSURANCE AND TREATING PHYSICIAN WOMAN
Health Insurance:
Employer:
Insurance Number:
Gynaecologist (Name and Address):
General Practitioner (Name and Address):

INSURANCE AND TREATING PHYSICIAN MAN
Health Insurance:
Employer:
Insurance Number:
Urologist (Name and Address):
General Practitioner (Name and Address):

RELATIONSHIP INFORMATIONS

- ☐ We hereby declare that we are married to each other.
- ☐ We live in a long-term partnership.

DATE, SIGNATURE WOMAN	DATE, SIGNATURE MAN

TFP Fertility Wels

ANAMNESIS WOMAN

PERSONAL DATA WOMAN

Name:

First Name:

Date of Birth:

Patient-ID:

ILLNESSES

Underlying diseases (e.g. high blood pressure, thyroid desease, liver and kidney disease, nerve disease, other):

Operations (type e.g. uterus, ovaries, cervix 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, strokes, heart attacks (in the family or with you):

Genetic diseases (in the family or with you, e.g. malformations, mental impairment, muscle weakness):

Chromosomal examination:

☐ yes ☐ no

DESIRE TO HAVE CHILDREN

Desire for children exists since:

Children or conceived pregnancies (e.g. 2010 birth of healthy boy, and type of birth e.g. caesarean section or vaginal birth):

☐ In current relationship ☐ In other relationship

Fertility treatment has already taken place (e.g. stimulation by a 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 strength (e.g. light, medium, strong, very strong):

Menstrual pains: ☐ yes ☐ no

Last period (first day):

MEDICATION

Regular medication
(preparation and dosage, e.g. Femibion 1 / day):

Drug allergy (if yes, which drugs?):

Other allergies:

OTHER INFORMATION

Smoking: ☐ yes ☐ no

Alcohol: ☐ yes ☐ no

Height (cm): Weight (kg):

DATE, SIGNATURE WOMAN

TFP Fertility Wels

ANAMNESIS MAN

PERSONAL DATA MAN

Name:

First Name:

Date of Birth:

Patient-ID:

ILLNESSES

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

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 family or with you, e.g. malformations, mental impairment, muscle weakness):

DESIRE TO HAVE CHILDREN

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

☐ In current relationship ☐ In other relationship

Fertility treatment has already taken place (e.g. stimulation by a gynaecologist, 2009 2x IVF):

Sexual intercourse (Are there problems and what kind of problems):

MEDICATION

Regular medication
(preparation and dosage, e.g. Femibion 1 / day):

Drug allergy (if yes, which drugs?):

Other allergies:

OTHER INFORMATION

Smoking	☐ yes	☐ no
Alcohol	☐ yes	☐ no

Height (cm): Weight (kg):

DATE, SIGNATURE MAN

TFP Fertility Wels

DECLARATION OF CONSENT FOR THE USE OF THE E-MAIL ADDRESS AND MOBILE PHONE NUMBER

As a TFP fertility clinic, we attach great importance to excellent patient service. An important part of this service is to be able to contact you easily and at short notice. We therefore ask you for consent.

Due to the legal situation, we are obliged to obtain your consent to these different service and communication offers individually.

Thank you very much!

PERSONAL DATA WOMAN	
Last Name:	First Name:
Landline:	Mobile Phone:
E-mail address:	

I HEREBY AGREE,	
☐	that the TFP Fertility Clinic reminds me of agreed appointments via my e-mail address.
☐	that the TFP Fertility Clinic will send me the information accompanying the care and treatment to my specified e-mail address.
☐	that the TFP Fertility Clinic or the TFP Group may contact me for the purpose of providing quality care via my e-mail address.
☐	that the TFP Fertility Clinic or the TFP Group will send me a monthly newsletter by e-mail. The newsletter contains reports about interesting developments in fertility medicine and from the TFP fertility centres.

You can revoke these declarations of consent at any time, either individually or in their entirety. Simply send an e-mail to wels@tfp-fertility.com and we will get back to you as soon as possible.

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

DATE, SIGNATURE WOMAN

TFP Fertility Wels

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

DATE, SIGNATURE MAN

TFP Fertility Wels

DECLARATION OF CONSENT FOR THE EXCHANGE OF INFORMATION WITH THIRD PARTIES

PERSONAL DATA WOMAN
Last Name:
First Name:
Date of Birth:
Patient ID:

REQUEST / TRANSFER OF PATIENT FILES

We hereby agree that my treating practice may obtain findings from the following service providers and transmit the findings collected from me to other treatment providers.

GYNAECOLOGIST
Mrs. / Ms. / Mr.Dr. med.:
Street & No.:
Post Code:
City:
Phone Number:
Fax Number.:

GENERAL PRACTITIONER
Mrs. / Ms. / Mr. Dr. med.:
Street & No.:
Post Code:
City:
Phone Number:
Fax Number:

INFORMATION TRANSFER TO THIRD PARTY (e.g. AFFILIATES, INTERPRETERS)

We agree that our treatment practice may share information with the following individuals if their identity has been established. This also applies to telephone enquiries.

PERSON 1
Mrs. / Ms. / Mr.:
Street & No.:
Post Code:
City:
Phone Number:
Fax Number.:

PERSON 2
Mrs. / Ms. / Mr.:
Street & No.:
Post Code:
City:
Phone Number:
Fax Number.:

I can revoke this declaration of consent in writing at any time. In case of incorrectly collected data, I have the right to have them corrected or deleted after having been informed by the practice. I have the right to receive information about my personal data at any time. I also have the right to file a complaint with the state data protection authority at any time.

DATE, SIGNATURE WOMAN

TFP Fertility Wels

DECLARATION OF CONSENT FOR THE EXCHANGE OF INFORMATION WITH THIRD PARTIES

PERSONAL DATA MAN
Last Name:
First Name:
Date of Birth:
Patient ID:

REQUEST / TRANSFER OF PATIENT FILES

We hereby agree that my treating practice may obtain findings from the following service providers and transmit the findings collected from me to other treatment providers.

UROLOGIST
Mrs. / Ms. / Mr. Dr. med.:
Street & No.:
Post Code:
City:
Phone Number:
Fax Number.:

GENERAL PRACTITIONER
Mrs. / Ms. / Mr. Dr. med.:
Street & No.:
Post Code:
City:
Phone Number:
Fax Number:

INFORMATION TRANSFER TO THIRD PARTY (e.g. AFFILIATES, INTERPRETERS)

We agree that our treatment practice may share information with the following individuals if their identity has been established. This also applies to telephone enquiries.

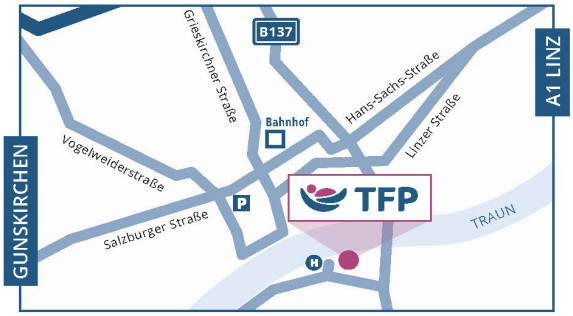
PERSON 1
Mrs. / Ms. / Mr.:
Street & No.:
Post Code:
City:
Phone Number:
Fax Number:

PERSON 2
Mrs. / Ms. / Mr.:
Street & No.:
Post Code:
City:
Phone Number:
Fax Number:

I can revoke this declaration of consent in writing at any time. In case of incorrectly collected data, I have the right to have them corrected or deleted after having been informed by the practice. I have the right to receive information about my personal data at any time. I also have the right to file a complaint with the state data protection authority at any time.

DATE, SIGNATURE MAN

DIRECTIONS - HOW TO GET TO US COMFORTABLY!



If you are travelling by car, public parking spaces are available for your use free of charge. These are located directly in front of our practice entrance. Please put a parking meter in the car.

When using a navigation device or a route planner, please always enter "Traunufer Arkade 1, 4609 Thalheim bei Wels" as your destination accordingly.

FROM VIENNA OR LINZ

- You are driving on the A1 motorway in the direction of Salzburg
- After the Haid junction, turn off onto the A25 in the direction of PASSAU.
- Leave the motorway at the WELS OST exit and drive straight ahead on the main road in the direction of Wels.
- After approx. 6 km you reach a large crossroads (McDonalds) and turn left towards Kirchdorf.
- At the third regulated crossroads turn right towards Thalheim (sign "KinderWunschKlinik")
- drive straight on through Thalheim
- after the BP petrol station you will see the TRAUNUFERARKADE on the right. The clinic is located in this building.

FROM GRAZ OR SALZBURG

- You take the A1 motorway in the direction of Linz
- Leave the motorway at the Voralpenkreuz/Sattledt junction and take the main road in the direction of Wels/Thalheim
- after approx. 10 kilometres turn left at the 2nd junction towards Thalheim (sign "Kinderwunschklinik")
- drive straight on through Thalheim
- after the BP petrol station you will see the TRAUNUFERARKADE on the right. The clinic is located in this building.