



Dr. med. univ. Markus Moser

Private Cardiology Practice

## Treatment Agreement & Privacy Notice

Patient's last name, first name: \_\_\_\_\_

Address: \_\_\_\_\_

**Treatment Agreement:** I wish to be examined and treated as a private patient. I understand that during the course of treatment, services may be provided whose costs may not be reimbursed, or may not be reimbursed in full, by my private health insurance or state aid office (Beihilfe). Regardless of reimbursement by third parties, I am obliged to pay the invoice. Billing is based on the GOÄ (§5 paras. 1-5 and §6 para. 2). Where additional effort is required, up to 3.5 times the standard rate may be charged (with justification). I undertake to keep agreed appointments or cancel them at least 24 hours in advance; otherwise, a cancellation fee may be charged.

Place, date: \_\_\_\_\_ Patient's signature: \_\_\_\_\_

**Data Protection & Consents (GDPR):** Personal data and health data are processed in accordance with statutory requirements, in particular the GDPR. Where necessary for providing treatment, we also use specialised service providers and software solutions.

- Red Medical practice software: electronic processing of medical data.
  - Eudaria documentation software: transcription and GDPR-compliant storage after review.
  - Doctolib: appointment management, patient communication and secure document exchange.
- Full information on data processing, service providers, legal bases, retention periods and your rights to access, rectification, erasure, restrict processing and object is provided in our full privacy notice, available at the practice or online.

Place, date: \_\_\_\_\_ Patient's signature: \_\_\_\_\_

### Consents:

**Doctolib: additional communication services**

☒ Receive appointment reminders by SMS/email

☒ Participate in the recall system (follow-up examinations)

### Important!

☒ **Billing via PVS HAG/BW:** I consent to the transfer of the required billing data to PVS HAG/BW and to the assignment of claims; otherwise payment by card on site.

**Billing is handled by PVS HAG/BW to reduce the administrative burden on the practice and to ensure correct and efficient processing of private medical services in accordance with the GOÄ. This allows staff and time resources to be focused primarily on medical care.**

Place, date: \_\_\_\_\_ Patient's signature: \_\_\_\_\_



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## Private Cardiology Practice

Dear Patient

To obtain as comprehensive an overview of your health as possible, I would ask you to answer a few questions about yourself in advance. Your answers will of course be treated confidentially.

### Personal Details

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

General practitioner: \_\_\_\_\_

Would you like us to send medical letters or test reports to you by email?

Please consider the associated data protection risk!

Yes No

☐☐

Insurance:

☐ Private ☐ Self-pay

Body data:

Height: \_\_\_\_\_ cm Weight: \_\_\_\_\_ kg

BMI: \_\_\_\_\_ Weight at age 20-30: \_\_\_\_\_ kg

Allergies:

☐ Yes ☐ No

If "Yes", which:

**Current symptoms:**

What is the reason for your current consultation?

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**Health questions:**

**Are you aware of any of the following conditions, and if so, since when?**

**Yes      No**

- |                              |                              |                                                                     |
|------------------------------|------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/>     | <input type="checkbox"/>     | <b>Hypertension</b>                                                 |
|                              |                              | What are your measured blood pressure readings:                     |
| <input type="checkbox"/>     | <input type="checkbox"/>     | Angina pectoris/chest tightness <b>Coronary artery disease</b>      |
| <input type="checkbox"/>     | <input type="checkbox"/>     | <b>Heart attack/</b> Stents                                         |
| <input type="checkbox"/>     | <input type="checkbox"/>     | <b>Other heart conditions/</b> heart valve defects                  |
| <input type="checkbox"/>     | <input type="checkbox"/>     | <b>Diabetes mellitus</b>                                            |
| <input type="checkbox"/>     | <input type="checkbox"/>     | Lipid metabolism disorder/ <b>elevated cholesterol levels</b>       |
| <input type="checkbox"/>     | <input type="checkbox"/>     | <b>Stroke</b>                                                       |
| <input type="checkbox"/>     | <input type="checkbox"/>     | Circulatory disorder of the legs                                    |
| <input type="checkbox"/>     | <input type="checkbox"/>     | <b>Lung disease/</b> bronchial asthma, chronic bronchitis           |
| <input type="checkbox"/>     | <input type="checkbox"/>     | Thrombosis/ <b>pulmonary embolism</b>                               |
| <input type="checkbox"/>     | <input type="checkbox"/>     | Stomach/intestinal diseases                                         |
| <input type="checkbox"/>     | <input type="checkbox"/>     | Blood disorders/ <b>clotting disorders</b>                          |
| <input type="checkbox"/>     | <input type="checkbox"/>     | <b>Cancer</b>                                                       |
| <input type="checkbox"/>     | <input type="checkbox"/>     | Mental health conditions/depression/anxiety disorders               |
| <input type="checkbox"/>     | <input type="checkbox"/>     | <b>Sleep disorder</b> (difficulty falling asleep or staying asleep) |
| <input type="checkbox"/>     | <input type="checkbox"/>     | Pauses in breathing at night (sleep apnea)                          |
| <input type="checkbox"/>     | <input type="checkbox"/>     | Operations/accidents, if yes, which?                                |
| <br><input type="checkbox"/> | <br><input type="checkbox"/> | <br>Other conditions                                                |
-

For men: Erectile dysfunction or loss of libido?

☐ Never ☐ Sometimes ☐ Often ☐ Always

For women: When was your last menstrual period? Is it regular?

**Yes      No** Have you had any of the following pregnancy-related conditions?

☐ ☐ Gestational hypertension

☐ ☐ (Pre)eclampsia

☐ ☐ Gestational diabetes

**Family medical history:**

**Have any first-degree relatives had the following conditions before age 60?**

**Yes      No**

☐ ☐ Hypertension

☐ ☐ Heart attack, CAD, stent implantation, bypass

☐ ☐ Stroke

☐ ☐ Lipid metabolism disorders, elevated cholesterol

☐ ☐ Diabetes mellitus

☐ ☐ Sudden heart death

☐ ☐ Dementia

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**Lifestyle:**

Do you smoke?

☐ **Yes**      ☐ **No**      If "Yes", how many cigarettes per day:      Since when:

Do you drink alcohol regularly?

☐ **Yes**      ☐ **No**      If "Yes", how much and how often:      Since when:

Do you exercise regularly?

☐ **Yes** ☐ **No**      ☐ more than 150 min/week      ☐ less than 150 min/week

What sports do you do?

Do you have any hobbies?

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**Social life:**

Are you in a committed relationship?

☐ **Yes**      ☐ **No**      ☐ **married**

Do you have children?

☐ **Yes** ☐ **No**      If yes - how many, sex, age:

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Is your partner overweight?

☐ Yes ☐ No

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**Occupation:**

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**Other:**

When was your last ECG/**exercise ECG**?

When was your last **24-hour blood pressure monitoring**?

Have you ever had a **cardiac catheter examination**?

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**Medication:**

Do you take medication regularly?

| Medication | Morning | Noon | Evening |
|------------|---------|------|---------|
|            |         |      |         |
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|            |         |      |         |
|            |         |      |         |
|            |         |      |         |
|            |         |      |         |

Is there anything else you would like to tell me?

Thank you!

Kind regards, Dr. med. univ. Markus Moser