Dear Patient

We are pleased that you have registered for a consultation at MVZ TFP Kinderwunschzentrum in Berlin (hereafter referred to as "TFP Fertility Center"). We would like to support you in the best possible way during the journey to your desired child. To do this, we initially require some documents to enable us to provide you the best possible medical treatment in accordance with the rules and regulations.

Please complete the enclosed documents and return them to us **in PDF format by e-mail to start_berlin@tfp-fertility.com at least two days before your consultation**. If you have any questions, please feel free to contact us at any time via +49 30 20 62 67 20 or by e-mail via start_berlin@tfp-fertility.com.

Important notice: Please submit all pages in full and cross out any pages or sections that do not apply to you. The corresponding positions are marked with an asterisk (*).

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 us and look forward to meeting you!

ADMISSION INFORMATION NEW PATIENT / PARTNER

PERSONAL DETAILS PATIENT	**PERSONAL DETAILS PARTNER***
Last name:	Last name:
First name:	First name:
Date of birth:	Date of birth:

ADDRESS / CONTACT DETAILS PATIENT	**ADDRESS / CONTACT DETAILS PARTNER***
Street and no.:	Street and no.:
ZIP code:	ZIP code:
City:	City:
Phone no.:	Phone no.:
Mobil phone no.:	Mobil phone no.:
E-mail-Address:	E-mail-Address:

HEALTH INSURANCE PATIENT	**HEALTH INSURANCE PARTNER***
Type of insurance: ☐ legally insured ☐ private	Type of insurance: ☐ legally insured ☐ private
Health insurance:	Health insurance:
Insurance no.:	Insurance no.:

PARTNERSHIP INFORMATION*

- ☐ We hereby declare that we are married to each other.
- ☐ We live in a partnership designed to last.
- ☐ We live in a same-sex partnership that is designed to last.
- ☐ I am single without a partnership.

DATE, SIGNATURE PATIENT	**DATE, SIGNATURE PARTNER***

DATA PROTECTION INFORMATION AND DECLARATION OF CONSENT FOR THE USE OF CONTACT DATA

PERSONAL DETAILS PATIENT	PERSONAL DETAILS PARTNER*
Last name:	Last name:
First name:	First name:
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 and has implemented extensive technical and organisational measures in its business processes for this purpose, as well as obliging its employees to maintain confidentiality. We protect your personal data to the best of our ability and, in particular, process your health data exclusively in the context of your medical treatment and collect it only as far as necessary (data economy).

Responsible for data processing is MVZ TFP Berlin GmbH (Managing Directors: Johannes Röhren, Kathleen Hahne-Schröder), Kronenstraße 55-58, 10117 Berlin, start_berlin@tfp-fertility.com, +49 30 20 62 67 20.

Our Data Protection Officer is Marion Meyer (QMedicus Akademie), Heimradstraße 6, 34130 Kassel, info@qmedicus.de, +49 160 95 22 42 41.

Purpose of data processing and legal basis

The collection of health data is a prerequisite for your treatment. It must be available to ensure careful treatment. The data concerned may include medical histories, diagnoses, therapy recommendations and results that we or other doctors collect, or it made available to us by other doctors (e.g. doctors' letters).

The data processing is based on the legal requirements in order to fulfil the treatment contract between you and your doctor and the associated obligations, in particular in accordance with §630 a-h BGB (Federal Civil Code), §10 Ärztliche Berufsordnung (Federal Medical Professional Code) and §80 SGB X (Federal Social Code X) and is subject to the legal basis according to Article 9 Paragraph 2h) GDPR (EU General Data Protection Regulation) in conjunction with §22 Paragraph 1 No. 1 b) BDSG (Federal Data Protection Act).

Recipients of your data

We only transfer your personal data to third parties if this is permitted by law or you have given your written consent. Recipients may primarily be other doctors, pharmacies, the medical service of the health insurance, medical associations and, for billing purposes, the association of statutory insurance doctors, health insurance companies and private medical clearing centers. The data is transferred for the processing of medical questions and questions arising from your insurance relationship, for the provision of individual medication or for the billing of the services provided to you. Should it be required to forward data to other recipients, we will contact you separately in each individual case.

If we use data processors, for example for IT services and maintenance, we ensure an appropriate level of data protection together with the service provider by adequate processing contracts in accordance with Article 28 GDPR as well as data protection certifications and, if applicable, EU standard contractual clauses. If applicable, please note the additional data protection declarations of our service providers, for example for video consultation.

Saving your data

We keep your personal data as long as is required to carry out your treatment. Mandatory legal obligations, especially medical and tax/commercial retention periods, remain unaffected by this. Depending on your treatment, there may be retention periods of 10 years (Federal Medical Professional Code), 30 years (Federal Genetic Diagnostics Act, Federal Transplantation Act) and 110 years (Federal Sperm Donor Register Act). After the retention periods have expired, your data will be deleted from our archives.

Saving your data

We would like to point out that the processing of personal data by us results in data subject rights in accordance with the data protection laws. You have the right to free in charge information, correction, deletion and restriction of the processing of your personal data. Furthermore, you have the right to data portability, the right not to be subject to a decision based solely on automated processing and the right of withdrawal. However, the legality of the processing is not revoked retroactively. Furthermore, you have the right to appeal to us or to the responsible data protection supervisory authority.

If you would like to address data subject rights or have questions regarding the processing of personal data by us, please contact our Data Protection Officer.

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.

Declaration of consent for data processing

I / WE HEREBY AGREE TO	
☐	that the TFP Fertility Center will remind me / us of agreed appointments by SMS via the provided phone number.
☐	that the TFP Fertility Center will remind me / us of agreed appointments via the provided e-mail address.
☐	that the TFP Fertility Center will send me / us accompanying information to my / our treatment or service by SMS via the provided phone number.
☐	that the TFP Fertility Center sends me / us the information accompanying care and treatment via the provided e-mail address.
☐	that the TFP Fertility Center or TFP Fertility Germany GmbH may contact me / us via the e-mail provided for the purpose of their own quality assurance.
☐	that the TFP Fertility Center or TFP Fertility Germany GmbH will send me / us a monthly newsletter by e-mail. The newsletter contains reports on interesting developments in fertility medicine and from the TFP Fertility Centers.

Your declaration of consent is made on a purely voluntary basis and can be revoked in full or in part at any time in written form with effect to the future. To do so, please contact our Data Protection Officer. Please also note the data protection information on the processing of your personal data. Further information on data protection is available on www-tfp-fertility.com.

I / we have received a copy of this declaration.

DATE, SIGNATURE PATIENT	**DATE, SIGNATURE PARTNER***

TFP Kinderwunsch Berlin

MEDICAL HISTORY

PERSONAL DETAILS PATIENT

Last name:

First name:

Date of birth:

Patient-ID:

PERSONAL DETAILS PARTNER*

Last name:

First name:

Date of birth:

Patient-ID:

MENSTRUAL PERIOD

First menstrual period at the age of

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

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

Bleeding intensity

☐ **light** ☐ **medium** ☐ **heavy**

Menstrual pain

☐ **no** ☐ **light** ☐ **medium** ☐ **heavy**

CONTRACEPTION

How have you used contraception in the past and for how long?

Method	**from**	**to**
Pill/contraceptive ring		
Mini Pill		
hormone sticks (Implanon)		
3-month-injection		
Hormone spiral		
Copper spiral		
Condom/Diaphragm		
Temperature/calendar method		

Last used contraception

GYNECOLOGICAL OPERATION

☐ **Curettage** When?

☐ **Hysteroscopy** When?

☐ **Laparoskopy** When?

GYNECOLOGICAL DISEASE

☐ **Endometriosis** ☐ **Ovarian cysts**

☐ **Fibroids** ☐ **PCO-Syndrom**

☐ **Others**

GYNECOLOGICAL INFECTIONS

☐ Fallopian tube inflammation When?

☐ Chlamydia infection When?

☐ Genital warts When?

☐ Others When?

When last?

With findings ☐ When?

CANCER SCREENING

Without any finding ☐

PREVIOUS PREGNANCIES

Year	Birth	Abortion	Determination	Ectopic pregnancy	Current partner	Fertility Treatment	Particularities
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	

SEXUAL MEDICAL HISTORY

Do you have sexual contacts? **No** ☐ **Yes** ☐ **if yes, next question**

How do you experience your sexual contacts??

☐ negative ☐ neutral ☐ positive

Do you have problems regarding sexual intercourse?

☐ No ☐ Yes if yes, which?

How often do you have sexual intercourse?

☐ about per week or about per month

☐ only around ovulation ☐ not at all

PATIENT

☐ Loss of libido

☐ Dryness of the vagina

☐ Spasm of the vagina

☐ Pain during sexual intercourse

☐ Orgasmic disorders

☐ Others

Does desire to have children influences your sexual life?

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

5 4 3 2 1 0 -1 -2 -3 -4 -5

positive neutral negative

PARTNER*

☐ Loss of libido

☐ Erectile dysfunction

☐ Ejaculation disorders

☐ Pain during sexual intercourse

☐ Orgasmic disorders

☐ Others

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

5 4 3 2 1 0 -1 -2 -3 -4 -5

positive neutral negative

TFP Kinderwunsch Berlin

MEDICAL HISTORY

PERSONAL DETAILS PATIENT

Last name:

First name:

Date of birth:

PERSONAL DETAILS PARTNER*

Last name:

First name:

Date of birth:

FAMILY MEDICAL HISTORY

Thrombosis	☐	yes, who?
Cancer	☐	yes, who?
Diabetes	☐	yes, who?
Others	☐	yes, who?

FAMILY MEDICAL HISTORY*

Thrombosis	☐	yes, who?
Cancer	☐	yes, who?
Diabetes	☐	yes, who?
Others	☐	yes, who?

DISEASES

- ☐ Thyroid disease
- ☐ Diabetes
- ☐ High blood pressure (since when?)
- ☐ Blood clotting disease
- ☐ Cancer/other tumors
- ☐ Mental disease
- ☐ Allergies
- ☐ Other diseases

DISEASES*

- ☐ Thyroid disease
- ☐ Diabetes
- ☐ High blood pressure (since when?)
- ☐ Blood clotting disease
- ☐ Cancer/other tumors
- ☐ Mental disease
- ☐ Allergies
- ☐ Other diseases
- ☐ Undescended testicles
- ☐ Mumps
- ☐ Varicose veins on the testicles

OTHER INFORMATION

Smoking: ☐ yes Cig/day: ☐ no

Alcohol: ☐ yes ☐ no

OTHER INFORMATION*

Smoking: ☐ yes Cig/day: ☐ no

Alcohol: ☐ yes ☐ no

MEDICATIONS

☐ no

Name	Dosage	Indication

MEDICATIONS*

☐ no

Name	Dosage	Indication

OPERATIONS

☐ no

Year	Clinic	OP

OPERATIONS*

☐ no

Year	Clinic	OP

I / we have had the desire to have children for years /months.

PREVIOUS FERTILITY TREATMENT

☐ no

Year	Clinic	Diagnosis

I am / We are / We have

- ☐ single.
- ☐ married.
- ☐ a registered partnership.

Have you ever fathered a child?*

- ☐ no
- ☐ yes ☐ with current partner.
- ☐ with another partner.

MISCELLANEOUS

DATE, SIGNATURE PATIENT

DATE, SIGNATURE PARTNER*

DECLARATION OF CONSENT FOR DATA TRANSFER WITH SERVICE PROVIDERS

PERSONAL DETAILS PATIENT	PERSONAL DETAILS PARTNER*
Last name:	Last name:
First name:	First name:
Date of birth:	Date of birth:

REQUEST / TRANSFER OF PATIENT FILES

I / we hereby consent that medical results can be transferred to or transferred from service providers who also treat me / us.

GYNAECOLOGIST	FAMILY DOCTOR / UROLOGIST
Ms. / Mr. Dr. med.:	Ms. / Mr. Dr. med.:
Street and no.:	Street and no.:
ZIP code:	ZIP code:
City:	City:
Phone no.:	Phone no.:
Fax no.:	Fax no.:

TRANSFER OF INFORMATION TO THIRD PARTIES (e.g. FURTHER DOCTORS, FAMILY MEMBERS, INTERPRETERS)

I / we agree that information may be passed on to the following persons if their identity has been checked. This also applies for enquiries via phone.

PERSON 1	PERSON 2
Ms. / Mr.:	Ms. / Mr.:
Street and no.:	Street and no.:
ZIP code:	ZIP code:
City:	City:
Phone no.:	Phone no.:
Fax no.:	Fax no.:

Your declaration of consent is made on a purely voluntary basis and can be revoked in full or in part at any time in written form with effect to the future. To do so, please contact our Data Protection Officer. Please also note the data protection information on the processing of your personal data. Further information on data protection is available on www-tfp-fertility.com.

I / we have received a copy of this declaration.

DATE, SIGNATURE PATIENT	DATE, SIGNATURE PARTNER*

DECLARATION OF CONSENT TO THE BILLING OF SERVICES FOR LEGALLY INSURED PERSONS*

PERSONAL DETAILS PATIENT	PERSONAL DETAILS PARTNER*
Last name:	Last name:
First name:	First name:
Date of birth:	Date of birth:

I / we were informed that the legal health insurance only partially cover or do not cover some services within the framework of fertility treatment.
I / we have taken note that these services will be invoiced in accordance with GOÄ (Federal Fee Schedule for Doctors, in the currently valid version) after prior cost clarification.

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

I / we ensure to pay 50% of the treatment cost as own contribution according to § 27a SGB V (Federal Social Code V, see 1.) respectively the fee calculated according to the GOÄ (under consideration of the maximum rates § 5 GOÄ) (see 2., 3. and 4.) after appropriate prior information.
It is possible to inspect a list of services according to GOÄ at your attending doctors office.

DATE, SIGNATURE PATIENT	DATE, SIGNATURE PARTNER*

DECLARATION OF CONSENT TO PRIVATE LIQUIDATION FOR PRIVATE INSURED PERSONS*

PERSONAL DETAILS PATIENT	PERSONAL DETAILS PARTNER*
Last name:	Last name:
First name:	First name:
Date of birth:	Date of birth:

I / we hereby apply for treatment and invoicing according to GOÄ (Federal Fee Schedule for Doctors, in the currently valid version) by the doctors of the TFP Fertility Center for the period of my / our treatment. Should I / we stop the treatment in the meantime and continue it later, this treatment contract remains valid and can only be declared invalid in written form.

I / we agree with the liquidation according to GOÄ.

§ 4 Abs. 5 (GOÄ)

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

I / we ensure to pay the fee calculated according to the GOÄ (under consideration of the maximum rates § 5 GOÄ) if a health insurance and/or other grant agencies do not cover it or do not filly adopt it.

DATE, SIGNATURE PATIENT	DATE, SIGNATURE PARTNER*

DECLARATION OF CONSENT FOR THE TRANSFER OF PSEUDONYMISED TREATMENT DATA

PERSONAL DETAILS PATIENT	PERSONAL DETAILS PARTNER*
Last name:	Last name:
First name:	First name:
Date of birth:	Date of birth:

We, as a center for reproductive medicine in Germany, participate in the reproductive medicine data collection of QSReproMed (located at the Medical Association of Schleswig-Holstein, www.qsrepromed.de), D.I.R - Deutsches IVF Register (www.deutsches-ivf-register.de) and FertiPROTEKT (www.fertiprotekt.com) for legal, professional and scientific reasons as well as for external quality assurance.

German IVF-Register e.V. (D·I·R)®
Responsible is the current Board of Directors
Lise-Meitner-Straße 14, 40591 Düsseldorf, Germany
Tel: +49 (0)211 913 848 00
E-mail: geschaeftsstelle@deutsches-ivf- register.de
Data Protection Officer: QuDaMed, Sonnemann / Strelecki GbR, info@qudamed.de

FertiPROTEKT Netzwerk e.V.
Responsible is the current Board of Directors
Weißdornweg 17, 35041 Marburg/Lahn
Tel.: +49 (0) 64 20 305 05 83
E-mail: info@fertiprotekt.com
There is no current legal obligation to appoint a Data Protection Officer.

Medical Association Schleswig-Holstein
Responsible is the current board of directors
Bismarckallee 8 - 12, 23795 Bad Segeberg
Tel: +49 (0) 4551 803 0
E-mail: info@aeksh.de
Data Protection Officer: Tel: +49 (0) 4551 803 251; E-Mail: datenschutzbeauftragte@aksh.de

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 Federal Sperm Donor Register Act and the requirements for pre-implantation diagnostics (§3a Federal Embryo Protection Act). A further legal basis is the legitimate and overriding interest (Article 6 Paragraph 1 S.1 lit.f GDPR/EU-General Data Protection Regulation) 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 informed consent.

Your collected data will be deleted or blocked as soon as the purpose of the processing no longer applies and the deletion does not conflict with any legal retention obligations.

The data collection includes required treatment data, which are pseudonymised via a patient identification number. The patient identification number is generated by us as the treating Fertility Center and is based on your date of birth, place of birth and birth name.

This allows your TFP Fertility Center to send pseudonymised data to the registers and your treatment data can be checked within this framework. The transmission of pseudonymised treatment data thus contributes significantly to quality assurance in reproductive medicine.

Each register only receives the data that is needed for the defined purposes. Your pseudonymised data is passed on in encrypted form in compliance with data protection regulations. Evaluations for statistical purposes by the registers are anonymised. If no therapy is carried out, no data is passed on to the registers.

Your declaration of consent is made on a purely voluntary basis and can be revoked in full or in part at any time in written form with effect to the future. To do so, please contact our Data Protection Officer. Please also note the data protection information on the processing of your personal data. Further information on data protection is available on www-tfp-fertility.com.

I / we have received a copy of this declaration.

DATE, SIGNATURE PATIENT	**DATE, SIGNATURE PARTNER***