KINDERWUNSCH
AM MAIN

ADMISSION INFORMATION FOR NEW PATIENT / PARTNER

PERSONAL INFORMATION OF THE PATIENT	PERSONAL INFORMATION PARTNER*
Surname:	Surname:
Last Name:	Last Name:
Date of birth:	Date of birth:

ADDRESS / CONTACT DETAILS PATIENT	ADDRESS / CONTACT DETAILS PARTNER*
Street & House No.:	Street & House No.:
Zip code:	Zip code:
City:	City:
Phone Number:	Phone Number:
Mobile / Mobile:	Mobile / Mobile:
E-mail address:	E-mail address:
Job:	Job:

HEALTH INSURANCE PATIENT	HEALTH INSURANCE PARTNER*
Type of insurance:	Type of insurance:
☐ Statutory ☐ Private ☐ Subsidy Insurance	☐ Statutory ☐ Private ☐ Subsidy Insurance
Health insurance:	Health insurance:
Insurance number:	Insurance number:

PARTNERSHIP INFORMATION*
☐ We hereby declare that we are married to each other.
☐ We live in a long-term partnership.
☐ We live in a long-term same-sex partnership.
☐ I'm single.

DATE, SIGNATURE PATIENT	DATE, SIGNATURE PARTNER*

KINDERWUNSCH
AM MAIN

INFORMATION ON DATA PROTECTION AND DECLARATION OF CONSENT TO THE USE OF CONTACT DETAILS

PERSONAL INFORMATION OF THE PATIENT	PERSONAL INFORMATION PARTNER*
Surname:	Surname:
Last Name:	Last Name:
Date of birth:	Date of birth:

When it comes to protecting your personal data, the Kinderwunsch Group attaches great importance to the highest standards in accordance with European and German data protection laws and has implemented extensive technical and organizational measures in its business processes and committed its employees to confidentiality. We protect your personal data in the best possible way and, in particular, process your health data exclusively in the context of your medical treatment and collect it only to the extent necessary (data minimisation).

Responsible for data processing is:

MVZ Kinderwunsch Rhein-Main GmbH (Managing Director: Kathleen Hahne-Schröder),

Mainzer Straße 98-102, 65189 Wiesbaden, wiesbaden@mvz-kinderwunsch.com, +49 611 97 63 20.

Our data protection officer is Marion Meyer (QMedicus Academy), Würflingerstraße 263a, CH-8408 Winterthurl, 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. They must be present to ensure careful handling. In addition to anamnesis, diagnoses, therapy suggestions and findings that we or other doctors collect, the data concerned also includes data provided to us by other doctors (e.g. doctor's letters).

The data processing is carried out on the basis of 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, §10 Medical Professional Code and §80 SGB X and is subject to the legal basis according to Article 9 (2h) GDPR in conjunction with §22 (1) No. 1 b) BDSG.

Recipients of your data

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

If we use processors, for example for IT services and maintenance, we work with the service provider to ensure an adequate level of data protection through data processing agreements in accordance with Article 28 GDPR as well as data protection certifications and, where applicable, EU standard contractual clauses. If applicable, please note the supplementary data protection declarations of our service providers, for example for video consultations.

Storage of your data

We will only keep your personal data for as long as is necessary to carry out your treatment. Mandatory statutory provisions, in particular medical and tax/commercial retention periods, remain unaffected by this. Depending on your treatment, there may be retention periods of 10 years (Professional Code of Conduct for Doctors), 30 years (Genetic Diagnostics Act, Transplantation Act) and 110 years (Sperm Donor Registry Act). At the end of the retention periods, your data will be deleted from our archives.

Storage of your data

We would like to point out that the processing of personal data by us results in data subject rights in accordance with data protection laws. You have the right to free 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 based solely on a

decision based on automated processing and a right of withdrawal. However, the lawfulness of the processing will not be retroactively revoked in the event of revocation. Furthermore, you have the right to lodge a complaint with us or the competent data protection supervisory authority.

If you would like to assert your rights as a data subject or if you have any 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 to be able to get in touch with you easily and at short notice. Therefore, we ask for the following consents.

Declaration of consent to data processing & sending of SMS / e-mail

I HEREBY AGREE/WE AGREE
☐ that Kinderwunsch am Main sends me prescribed e-prescriptions via the mobile phone number provided as a link by SMS.*
☐ that Kinderwunsch am Main reminds me / us of agreed appointments via the e-mail address provided.
☐ that Kinderwunsch am Main sends me/us treatment-relevant information to the e-mail address provided.
☐ that Kinderwunsch am Main or Kinderwunsch Germany GmbH may contact me / us for the purpose of their own quality assurance via the specified e-mail.

***Since January 1, 2024, the use of e-prescriptions for prescription medications has been mandatory, which is why we, as a fertility center, always send you a link by SMS to the number provided to us when creating an e-prescription, which you can use to redeem your e-prescription at the pharmacy. <u>For this, the consent in the first point 1 is a prerequisite!</u> Please make sure that your mobile phone number is entered correctly and inform the practice staff immediately of any changes.**

Your declaration of consent is purely voluntary and can be revoked in full or in part at any time in writing with effect for the future. To do so, please contact our data protection officer. In addition, please note the data protection information on the processing of your personal data. For more information on data protection, please visit www.mvz-kinderwunsch.com.

I have/have received a copy of this declaration.

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

KINDERWUNSCH AM MAIN

ANAMNESIS PATIENT*

PERSONAL INFORMATION OF THE PATIENT

Surname:

Last Name:

Date of birth:

*in the case of same-sex couples, please fill out this form from both patients

DISEASES

Underlying diseases, infectious diseases (e.g. high blood pressure, thyroid disease, hepatitis/HIV virus infection):

Thrombosis (in the family or in you):

Genetic diseases (in your family or in you):

FERTILITY

The desire to have children has existed since:

Children or pregnancies conceived
(e.g. in 2020, birth of a healthy baby or miscarriage in 2021):

☐ In current partnership ☐ In a different partnership

Fertility treatment that has already taken place
(e.g. stimulation at the gynecologist, 2x IVF in 2019):

PRELIMINARY TESTS

Endometriosis? (Yes / No)

Operations (type and year of surgery):

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

Last smear at the gynecologist (date / findings):

CYCLE

First menstrual period mit_____ years.

Cycle length (e.g. 26 – 28 days):

Duration of bleeding (e.g. 4 – 5 days):

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

Last period (first day):

Menstrual Pain (Yes / No):

MEDICATION

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

Allergies (please also indicate medication allergies, if any)

OTHER INFORMATION

Smoke	☐ yes	☐ no
Alcohol	☐ yes	☐ no

Height (cm): Body weight (kg):

DATE, SIGNATURE PATIENT

KINDERWUNSCH AM MAIN

ANAMNESIS PARTNER (MALE)

PERSONAL INFORMATION MAN

Surname:

Last Name:

Date of birth:

DISEASES

Underlying diseases, infectious diseases (e.g. high blood pressure, thyroid disease, hepatitis/HIV virus infection):

Operations (type and year of surgery):

Undescended testicles in childhood (yes / no):

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

Genetic diseases (in your family or in you):

FERTILITY

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

☐ In current partnership ☐ In a different partnership

Fertility treatment already carried out
(e.g. stimulation at the gynecologist, 2x IVF in 2009):

MEDICATION

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

Allergies (please also indicate medication allergies, if any)

OTHER INFORMATION

Smoke	☐	yes	☐	no
Alcohol	☐	yes	☐	no

Height (cm): Body weight (kg):

DATE, SIGNATURE PARTNER

KINDERWUNSCH
AM MAIN

DECLARATION OF CONSENT FOR DATA TRANSFER WITH SERVICE PROVIDERS

PERSONAL INFORMATION OF THE PATIENT	PERSONAL INFORMATION PARTNER*
Surname:	Surname:
Last Name:	Last Name:
Date of birth:	Date of birth:

REQUEST/SUBMISSION OF PATIENT RECORDS
I agree / we hereby agree that practice findings will be obtained from the following service providers and that findings collected from me / us will be transmitted to co-treating service providers.

GYNAECOLOGIST	GENERAL PRACTITIONER / UROLOGIST
Mrs. / Dr. med.:	Mrs. / Dr. med.:
Street, house no.:	Street, house no.:
Zip code:	Zip code:
City:	City:
Tel.-No.:	Tel.-No.:
Fax No.:	Fax No.:

DISCLOSURE OF INFORMATION TO THIRD PARTIES (e.g. other practices, relatives, interpreters)
I/we agree that information will be shared with the following persons, provided that their identity has been established. This also applies to telephone enquiries.

PERSON 1	PERSON 2
Mrs. / Mr.:	Mrs. / Mr.:
Street, house no.:	Street, house no.:
Zip code:	Zip code:
City:	City:
Tel.-No.:	Tel.-No.:
Fax No.:	Fax No.:

Your declaration of consent is purely voluntary and can be revoked in full or in part at any time in writing with effect for the future. To do so, please contact our data protection officer. In addition, please note the data protection information on the processing of your personal data. For more information on data protection, please visit www.mvz-kinderwunsch.com.

I have/have received a copy of this declaration.

DATE, SIGNATURE PATIENT	DATE, SIGNATURE PARTNER*

DECLARATION OF CONSENT TO BENEFIT BILLING FOR PERSONS WITH STATUTORY HEALTH INSURANCE*

PERSONAL INFORMATION OF THE PATIENT	PERSONAL INFORMATION PARTNER
Surname:	Surname:
Last Name:	Last Name:
Date of birth:	Date of birth:

I / we were informed that the statutory health insurance companies only partially or not cover some services in the context of fertility treatment.
I / we have taken note of the fact that these services will be liquidated after prior cost clarification in accordance with the GOÄ (Fee Schedule for Doctors, as amended).

§ 4 para. 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 / we undertake to bear the 50% personal contribution of a treatment according to § 27a SGB V (see 1.) or the fee calculated according to the GOÄ (in compliance with the maximum rates § 5 GOÄ) (see 2., 3. and 4.) after corresponding prior information.

It is possible to inspect a list of services according to GOÄ from your attending physician.

DATE, SIGNATURE PATIENT	DATE, SIGNATURE PARTNER*

DECLARATION OF CONSENT FOR PRIVATE LIQUIDATION FOR PRIVATE PATIENTS*

PERSONAL INFORMATION OF THE PATIENT	PERSONAL INFORMATION PARTNER
Surname:	Surname:
Last Name:	Last Name:
Date of birth:	Date of birth:

I hereby apply for treatment and calculation according to GOÄ (Fee Schedule for Doctors, in the currently valid version) by the doctors of the desire to have children at the Welfenhof for the period of my / our treatment. Should I/should we interrupt the treatment in the meantime and continue it at a later date, this treatment contract will continue to be valid and can only be declared invalid in writing.

I agree to the liquidation according to GOÄ (Fee Schedule for Doctors).

§ 4 para. 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 / we undertake to bear the fee calculated in accordance with the GOÄ (in compliance with the maximum rates § 5 GOÄ) myself, provided that insurance companies and/or aid agencies do not cover it or do not cover it in full.

DATE, SIGNATURE PATIENT	DATE, SIGNATURE PARTNER*

KINDERWUNSCH
AM MAIN

DECLARATION OF CONSENT FOR SORP MEASUREMENT IN SEMEN PARTNER (MALE)*

*Test is only possible in the ÜBAG MVZ Kinderwunsch am Welfenhof

PERSONAL INFORMATION MAN

Surname:	
Last Name:	
Date of birth:	
Patient ID:	

The classic semen analysis is limited in its informative value with regard to the diagnosis of fertile/infertile. This means that despite a diagnosis of "inconspicuous findings", up to 40% of this group are infertile men.

Up to 25-40% of infertile men and up to 80% of men with so-called idiopathic sterility have significantly higher levels of ROS (ROS=reactive oxygen species, or free oxygen radicals) in their semen.

Oxidative stress is one of the main factors in male infertility. High levels of oxidative stress are associated with poor sperm quality. The main cause of DNA damage is oxidative stress.

Routine semen analysis does not detect oxidative stress. The measurement of this parameter is an additional diagnostic method for determining sperm quality.

With the MiOXSYS® system, we have a diagnostic tool at our disposal that determines all known and unknown oxidants and reductants.

The sORP measurement as part of basic diagnostics is currently not reimbursed by the statutory cost bearers and is therefore billed privately.

Service description	GOÄ number	Number	Factor	Total
Consultation	1	1	2,3	from 10,72 € incl.
Carrying out a functional test	3693A	1	1,3	from 43,19 €
Total costs				**from 53,91 €**

I have read the patient information on sORP measurement in semen in full, understood the content and have no further questions about it.

I agree to carry out the analysis and hereby confirm that I will bear the costs myself:

DATE, SIGNATURE PARTNER*