Application Form

Last Name: _____ Date of Birth: _____

First Name: _____ Occupation _____

Street / No: _____ Tel. private: _____

ZIP/Residence: _____ Tel. mobile: _____

E-Mail: _____

Health Insurance: statutory: ☐ private: ☐

(Please x all that apply)

Name of Insurance: _____

exempted from co-payment? yes ☐ no ☐

(Please x all that apply; exemption has arrived)

If you are not exempted from co-payment according to medical prescription,
deliverables of physiotherapy require a co-payment of 10 %.
There is also a levy of €10.00 for each prescription.
These amounts shall be immediately due and payable with your first treatment.

I hereby notice the current fee for deliverables of physiotherapy
and prevention in this practice and agree to them.

I know that I must cancel appointments not later than 24 hours before in case of missing.
I also know that unexcused missed or belated cancelled appointments
will be invoiced amounting to €15.00 for each commenced 20 minute.

We will save patient data computerized for billing and documentation
and send them to our billing center Optica.

_____ _____

Date Signature