Registration form for privately insured clients

(Please complete in full and return by email to info@ergotherapie-karlsruhe.de)

_____

👤 Personal details

Surname, first name: _____

Date of birth: _____

Full address:

Street / house number: _____

Postcode / Town: _____

_____

👶 Details for minors

Full name of the person registering:_____

_____

📞 Contact details

Telephone (private): _____

Mobile: _____

Telephone (business): _____

Email: _____

_____

🩺 Medical information

Referring doctor:

_____

Diagnosis (according to doctor's prescription) Desired therapy method (if applicable) (neurofeedback training, biofeedback training, concentration group, EST training):

_____

health insurance :

_____

💶 Statutory co-payment (from 18 years of age)

According to Social Security Code V, persons with statutory health insurance **aged 18** and over are required to pay

10% of the treatment costs and **EUR 10,00 per prescription** for remedies themselves.

Co-payment amounts (individual prices):

- Analysis of occupational therapy needs (only for initial prescriptions): **4,15€**
- Motor-functional treatment: **5,69€**
- Sensory-motor-perceptual treatment: **7,59€**
- Psychological-functional treatment: **9,49€**
- Brain training: **4,15€**
- Thermal application: **0,85€**
- Travel expenses for home visits: **2,76€**

☐ **Exempt from co-payments**

(Please present a valid exemption card)

_____

🕒 Available appointment times

Please indicate **which days of the week and at what times**

we can schedule you on a regular basis:

Mon _____

Tue _____

Wed _____

Thu _____

Fri _____

_____

📄 Information on prescription of remedies

If you already have a prescription, which remedy was prescribed?

(Please tick)

☐ Sensory-motor-perceptual treatment (45 minutes)

☐ Psychological-functional treatment (60 minutes)

☐ Brain training / neuropsychologically oriented treatment (30 minutes)

☐ Motor-functional treatment (30 minutes)

Did the doctor prescribe a home visit?

☐ Yes ☐ No

🏡 Everyday life & activities

Please list **three activity problems** from your everyday life

or from your child's everyday life:

1. _____
2. _____
3. _____

_____

📎 Available documents

☐ Medical reports

☐ Hospital reports

☐ SPZ / Early intervention centre

☐ Other: _____

(Please bring any available documents with you to your first appointment)

📌 Practice rules & consent

Please read and tick:

☐ I agree to cancel any appointments that I am unable to attend

as early as possible.

☐ I am aware that appointments that **are not cancelled by 9:00 a.m. on the day of treatment** will be charged a cancellation fee of **40,00€.** Cancellations after 9:00 a.m. **cannot be taken into account, even in unforeseeable situations.**

☐ I agree that the personal data required for billing purposes may be transferred to a **billing centre**.

☐ I release the practice from its duty of **confidentiality towards the prescribing doctor.**

The points ticked above represent our **practice rules**. They form **the basis of our cooperation**. If these rules are not accepted or adhered to, we reserve the right to terminate the cooperation.

Place, date: _____

Signature of client/legal guardian:

_____