



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. Please note that our neurofeedback training is exclusively focused on **concentration and relaxation training, mild to moderate depression, and tinnitus**. We do not specialise in the treatment of PTSD, anxiety disorders, severe depression, etc. In the area of biofeedback training, we specialise exclusively in the treatment of **migraines**.):

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:** _____

Information and consent to the use of unsecure communication channels

I, _____, born on _____, residing at _____, hereby declare that I consent to the transmission of the following personal data (e.g. appointment details, contact details, findings) by the practice "Praxis für Ergotherapie Stefanie Baumann & Renée Weil" via the following communication channels without further security measures and in particular without further encryption.

Email to the following address:

WhatsApp to the following number:

I have been expressly informed by the practice that this transmission channel is not secure and poses risks to my data. I am aware that I can revoke this declaration at any time without giving reasons, with future effect.

Place, date

Signature of the patient, legal representative



Have you filled everything in?

Please check that you have filled in all the fields. Please note that only correctly completed registration forms can be processed. Thank you for your understanding.