ELLANN®
HEALTH

TREATMENT CONTRACT

Last name / First name: _____ Date of birth: _____

Street: _____ Postal code: _____ City / town: _____

I hereby declare that I want and am expressly requesting the diagnostics and the subsequent therapy to be carried out. I have been adequately and comprehensively informed by the doctor. I was informed about all diagnostic and therapy procedures, their implementation and effect, to be carried out in the time period stated above, and had the opportunity to ask questions. I have understood this information and had time to consider and/or obtain information from other sources. Based on all the information and deliberation, I expressly agree to the application and implementation of the diagnosis and therapy, and hereby request them.

In the informed consent discussion, I was expressly informed that I am in a **private facility**, have concluded a contract for services and that billing will be in the form of a private invoice to me based on the German medical fee schedule (GOÄ).

I also confirm this especially and expressly for services that, according to prevailing opinion, **are not considered medically necessary** or do not correspond to the guidelines of the Federal Committee and therefore **constitute a treatment attempt**. As a result, I am aware that no guarantee of success can be given that the treatment provided will lead to recovery or an improvement of my symptoms. I am also aware that this is a special treatment that is not offered at every clinic or practice (in particular INUSpherese®). I was informed in detail, personally by the doctor, in particular also with regard to my documented diagnoses as indications.

Reimbursement of the costs by insurance providers is **not ensured.** To the extent the invoiced costs for the diagnostic and therapy services provided to me are not covered by assistance, supplementary insurance, statutory insurance or private insurance, I declare and confirm with my signature **that I shall pay the full amount of the invoice in any case, regardless of cost coverage by my insurance provider**. I also declare that I have the necessary funds and that payment will not cause me economic hardship. I have made my decision freely, under consideration of all information and with full awareness.

I hereby exclude the assignment of all mutual rights arising from this agreement to third parties, regardless of the legal basis. In particular, subrogation according to Section 86 of the German Insurance Contract Act, new version or Section 67, old version is excluded.

I consent to the collection and processing of personal data recorded in the course of registration/treatment. The data may be used exclusively for processing according to this treatment contract and for general medical care. The data may also be sent to laboratories with laboratory materials via Laborfahrer, GO Express or DHL. This must be done in accordance with the applicable data protection law regulations. My patient data may be used anonymously for studies or statistical purposes in terms of medical publications.

Signature of patient: _____ E-mail: _____

I expressly consent to have my findings sent by e-mail (enter e-mail address) or by mail. Please cross out if not applicable.

I have been informed that I may object to and revoke the consent to use at any time.

Based on the current clinical condition and the case history of the insured person, approximately _____ treatments with INUSpherese® are considered appropriate. The costs were signed in a separate fee contract that I have received.

Place / date: _____ Signature of patient: _____

Place / date: _____ Signature of the doctor: _____

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