functiomed
Zentrum für funktionelle Medizin

PATIENT REGISTRATION

Surname / Cognome / Nom:

First name / Nome / Prénom:

Gender: m / f / other

Date of birth / Data di nascita / Date de naissance:

1

phone / mobile:

Email:

Street/no.:

Postcode/place of residence:

General practitioner:

Health insurance provider:

Insurance no.:

Legal representation (please fill in if there is one and if not identical to the patient's personal details)

Surname and first name:

Email:

Patient Declaration

- ✓ By providing my signature, I confirm that I agree to the processing of my data, to my data being accessed by the doctor or therapist, and to the transfer of my data to third parties in accordance with the Information for Patients on the Handling of Patient Data, on the following page.
- ✓ By providing my signature, I confirm that I have read and understood the Information for Patients and the Patient Declaration. If I have any questions or if anything is unclear to me, I will contact the doctor or therapist providing my treatment.
- ✓ I authorize my doctor/therapist to request medical files such as examination findings, image material, expert opinions, files from authorities, insurance companies, assessments, as well as doctor's or hospital reports on completed and ongoing treatments about me for inspection and to forward them in my interest. I am aware that I can revoke this declaration of release from the duty of confidentiality at any time with effect for the future.
- ✓ I consent to my email address being used for the functiomed newsletter.

- ✓ I am aware of the possible risks of exchanging particularly sensitive personal data (possible access by unauthorised third parties in the event of insecure communication channels) as well as of my rights, and I give my consent to contact being made mutually between my doctor, my therapist, the functiomed health staff and me as a patient, by menas of the contact information provided above. Patient information is passed on by the health practice via secure communication channels whenever possible. I consent to administrative requests, such as rescheduling appointments, using unencrypted email communication (@hin-address/@functiomed address to recipient address, such as @bluewin.ch, @gmail.com, etc.)

Complementary medicine and non-compulsory services

- the patient is obliged to check the reimbursement of costs with the complementary or accident insurance before the appointment
- Billing according to time spent, per 5 minutes or part thereof according to the rate 590
- Studying files and keeping the medical history is part of the consultation time
- Direct billing of services to insurance companies is not permitted in complementary medicine
- Patients without supplementary insurance are treated as private patients/self-payers
- treatment must be paid for on site using TWINT and EC/Maestro cards (no American Express), cash payments possible, but we do not have change
- a surplus of CHF 3.50 will be charged for postal delivery
- You will receive the reimbursement voucher for your insurance by e-mail
- Reminder fees for late payment: 1st reminder CHF 5.- / 2nd reminder CHF 10.-

Patient Information for Manual Therapy

We are legally obliged to inform you about rare, but possible, complications caused by mobilisation and manipulation performed in manual therapy. Having complete information about pre-existing conditions and chronic diseases, which are recorded in your medical history, is important in this regard. For example, despite proper implementation of manual therapeutic treatment on the cervical, thoracic and lumbar spine, an as yet clinically dormant herniated disc can become symptomatic. Symptoms include tingling, numbness, and muscle paralysis in the arms or legs. In addition, in very rare cases, treatment of the cervical spine can lead to vascular injury of the vessels supplying the brain (stroke). Furthermore, a vertebral body can break during treatment if previously undiagnosed osteoporosis or metastases is/are present. However, there are always treatment alternatives when manipulation using manual therapy methods is not an option. If you have any questions or if anything is unclear to you, please contact the doctor or therapist providing your treatment.

Patient Information for Joint Injections / Infiltration / ACP / Dry Needling

Despite proper execution and compliance with all criteria regarding sterility, these treatments can trigger side effects. These include local haematomas at the site of treatment or a sensation comparable to a muscle ache near the spot of treatment. Further side effects could appear as an infection of the respective joint or the surrounding soft tissue as well as allergic reactions. Other complications of dry needling can include injury to internal organs (such as the lungs), injury to nerves or blood vessels, or needle breakage. People with weak immune systems, in particular, are at an increased risk for this. As mentioned, these complications are extremely rare and are listed here solely for the sake of completeness. If you suddenly develop severe pain symptoms, redness, swelling, fever or chills after the procedure, please contact us immediately or go to the nearest hospital.

Patient Information IV-therapy / vitamin infusions

This document confirms my consent to IV therapy. I have disclosed all current medications and supplements as well as any known allergies and previous reactions to anesthetics. I understand that I will be informed about the procedure, possible alternatives, and the risks and benefits of IV therapy. By signing below, I acknowledge that this procedure involves the insertion of a needle into the veins and the administration of an IV solution, which is considered an off-label use in Switzerland.

The potential risks of IV therapy are: Occasional: Discomfort, bruising, pain at the injection site. Rare: Phlebitis, phlebitis, metabolic disorders, injury. Extremely rare: Severe allergic reactions, anaphylaxis, infections, cardiac arrest, death. I am aware of the possible unforeseeable complications and trust the medical staff to act to the best of their knowledge and belief. I understand the risks and benefits of the procedure and have had the opportunity to ask any questions. I understand that I have the right to consent to or refuse treatment at any time. By signing below, I acknowledge that I have consented to IV therapy and understand that all nutrient infusions are considered experimental and not standard care.

Date/Data/Date: **Signature**/Company/Signature: