

Medical insurance company/payer:

Patient's surname, first name and address:

Date of birth

Surname and first name of legal representative/invoice recipient*

Date of birth

* For persons under 18 years of age/who are legally incompetent/who have limited legal competency.

Dear Patient,

We would like to wholly devote our attentions to you and your care. We have therefore decided to place the management of our patient invoices in the hands of a trusted partner. EOS Health Honorarmanagement AG, or Health AG for short, will see to the speedy and correct processing of your invoices. This will reduce our administrative workload, giving us more time to focus on you.

If you have questions regarding an invoice or wish to pay in convenient instalments, please contact Health AG. Your details are in good hands with them – the company handles your data as prescribed by Germany's Federal Data Protection Act (BDSG) and does not share it with third parties without authorization. We need your written consent in order for Health AG to handle your invoices. We therefore ask that you sign this declaration of consent.

Thank you!
Your surgery/clinic team

EOS Health
Honorarmanagement AG
Patientenservice
Lübeckertordamm 1-3
20099 Hamburg

Tel. 040 524 709-000
Fax 040 524 709-020
info@healthag.de
www.healthag.de



Declaration of consent

The patient makes the following declaration, if necessary represented by a legal representative with sole power of attorney:

I consent to

- the information required for the purposes of invoicing and asserting claims relating to treatment, in particular data in my patient records (name, address, date of birth, results, treatment data and progress, etc.), being passed on to and recorded by Health AG,
- Health AG issuing invoices in its own name and on its own account,
- the aforementioned information, in particular data in my patient records (see above), being passed on to SPV Health Finanzierungs-GmbH, Kurfürstendamm 125a, 10711 Berlin, Germany, and
- the claim(s) relating to my treatment being assigned to Health AG and, for the purposes of refinancing, to the claim(s) being reassigned by Health AG to SPV Health Finanzierungs-GmbH

and, as such, release my doctor/the surgery/clinic (cf. surgery stamp) from the duty to observe doctor-patient confidentiality insofar as this is necessary in order for Health AG or SPV Health Finanzierungs-GmbH to assert their claims. I am aware that objections to a claim are to be raised with Health AG and that this may necessitate details of my treatment being disclosed and that my doctor/the surgery/clinic may be questioned as a witness in the event of a dispute with Health AG.

This declaration qualifies as notification pursuant to Section 33 BDSG.

I further agree to my doctor/the surgery/clinic or Health AG obtaining information regarding my credit history from credit reference agencies, e.g. from Bürgel Wirtschaftsinformationen GmbH & Co. KG, Postfach 50 01 66, 22701 Hamburg, Germany, in particular my recorded address and credit rating data, including probability values as calculated on the basis of mathematical and statistical methods.

I hereby give my consent voluntarily and have been informed of the fact that treatment is not dependent on my granting this consent. My consent also applies to future treatment and may be revoked by me at any time for future treatment by writing to my doctor/the surgery/clinic or Health AG.

Date

Surgery/clinic stamp

Patient's/legal representative's signature