Clinic

Surname, first name, address of insured person **

Born on the **

**Please fill in these fields*

Dear patient,

we want to concentrate fully on you and your treatment. Therefore, we decided to transfer the billing to a competent partner:

APZ | ALPHAZAHN GbR
Ostring 6, 76313 Karlsruhe
Phone: +49 721 90986500
E-Mail: info@apz-alphazahn.de

APZ | ALPHAZAHN guarantees the swift, uncomplicated and correct processing of your invoice. APZ | ALPHAZAHN is yours too friendly and competent contact in all matters of the bill.

Consent form*

To the billing in cooperation with APZ | ALPHAZAHN, we need your written consent. Therefore we ask for yours approval by signing the below and adjacent explanations. Of course it is APZ | ALPHAZAHN (according to the EU- data protection regulation) on confidentiality committed. We thank you for your trust.

Legal Representative (s) to Minors / Unemployed / Limited Busines:

First name

Surname Date of birth

Street

Post Code/CIty

Position to the patient:

Father Mother Other

I expressly agree with the disclosure required for the purpose of billing information, in particular data from the patient card (name, date of birth, address, findings, treatment data) to APZ | ALPHAZAHN GbR, Ostring 6, 763131 Karlsruhe. Germany.

I am aware that I may revoke the transfer of my personal data at any time by email to info@apz-alphazahn.de.

Confidentiality release

I deliver my therapist of his / her confidentiality, insofar as this is necessary for the settlement of private services and the additional cost agreement is required. A multiple production of these I have received clarification. This approval also applies to future treatments. However, it is possible to revoke these before further treatment.

Place/Date

Signature patient, legal representative

Stamp

Deletion and / or changes to the above statements are not permitted and invalidate the declaration of consent.

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