

Treatment Contract & Consent Forms (privately insured)

Patient Details:

Last Name, First Name: _____

Date of Birth: _____

Address (Street, City, Zip): _____

E-Mail: _____

Phone Number: _____

Health Insurance: _____

A. Treatment Contract and Fee Agreement

I request private therapeutic treatment/consultation from Leonie Kruse (Facharztzentrum VerifyMED)

Important note regarding reimbursement: We are a private practice without a contract with statutory health insurance ("not covered by statutory health insurance"). This means that the costs of this treatment are not covered by statutory health insurance (statutory health insurance). I bear the costs privately in full as a self-payer.

Agreed Services and Fees (based on the German Catalogue of Therapeutic Remedies): The following fees are expected to be incurred during the treatment (depending on medical necessity):

Occupational Therapy Services

Sensorimotor -perceptual treatment (5-fold): **67,54€**

Motor-functional treatment (5-fold): **50,68 €**

Psychological-functional treatment (2,3-fold): **84,43€**

Thermal applications (heat/cold) (2,3-fold): **18,10€**

Functional assessment per prescription case (2,3-fold): **69,46€**

Physician contact/ communication pr prescription (2,3-fold): **25,61€**

Written progress report (2,3-fold): **48,41€**

Occupational therapy functional analysis (3,5 fold): **63,96 €**

Domicile visits:

Home visits per appointment (2,5 fold): **52,14€**

Travel reimbursement per kilometer (5-fold): **26,07€**

Splint Fabrication – Hand Therapy Area

Custom finger splint(5-fold): **63,69€**

Custom forearm / immobilization splint (5-fold): **63,69€**

Custom thumb splint (5-fold): **49,17 €**

Thermoplastic splint (2,5 fold): **68,90€**

Splint adjustment/ modification/ repair (2,5-fold): **35,64€**

I have read and accepted the contract and the cost estimate.

Place/Date/Signature:

Signature Therapist (Leonie Kruse):

