ZFM
ZENTRUM FÜR MOBILITÄT

Admission - Data protection form

Dear patient,
we kindly ask you to sign the following data for admission to the ZFM – Zentrum für Mobilität.

MAIN DATA:

First name: _____

Last name: _____ Academic title: _____

Street + House number: _____

Postcode: _____ City: _____ Phone: _____

Employer: _____

Insurance number / Date of birth: _____ / _____

Health insurance: _____

Private insurance (multiple selection possible):

- ☐ no specification
- ☐ no additional insurance
- ☐ ambulatory services only
- ☐ hospital only - SKM (two bed)
- ☐ hospital only - SKE (one bed)
- ☐ hospital only - don´t know
- ☐ emergency hospital only - SKM (two bed)
- ☐ emergency hospital only - SKE (one bed)
- ☐ emergency hospital only - don´t know
- ☐ emergency hospital & private doctor - SKM (two bed)
- ☐ emergency hospital & private doctor - SKE (one bed)
- ☐ emergency hospital & private doctor - don´t know
- ☐ hospital & private doctor - SKM (two bed)
- ☐ hospital & private doctor - SKE (one bed)
- ☐ hospital & private doctor - don´t know

Main insured person:

First name: _____

Last name: _____ Academic title: _____

Insurance number / Date of birth:

Health insurance: _____

Please note the following page

ZFM – Zentrum für Mobilität GmbH
Argentinierstraße 71/14 · 1040 Wien · AT
Entrance: Wiedner Gürtel 18/Corner Argentinierstraße
+43 (0)1 22 6 9898 · www.zfm.wien

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HEALTH ISSUES

Covid-19-vaccination: ☐ yes ☐ no Nr. of vaccinations: _____ Date last vaccination: _____

Covid-19-infection: ☐ yes ☐ no Date: _____

Allergies to medication: ☐ yes ☐ no

If yes, which ones? _____

Kidney/liver diseases: ☐ yes ☐ no

If yes, which ones? _____

Stomach/intestinal diseases: ☐ yes ☐ no

If yes, which ones? _____

Diabetes/sugar disease: ☐ yes ☐ no

If yes, which ones? _____

Are you taking blood thinning medication? ☐ yes ☐ no

If yes, which ones? _____

Infectious diseases (hepatitis, HIV, ...): ☐ yes ☐ no

If yes, which ones? _____

Are you pregnant or breastfeeding? ☐ pregnant ☐ breastfeeding ☐ no

Do you have any implants (pacemakers, prosthetic joints)? ☐ yes ☐ no

If yes, which implantante do you have? _____

Please inform us of any changes in your underlying conditions or if you are taking new medications.

_____

_____

Please note the follong page

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CONSENT ACCORDING TO DATA PROTECTION ACT (DSG) AND BASIC DATA PROTECTION REGULATION (EU) 2016/679

DECLARATION OF CONSENT

I agree that ZFM – Zentrum für Mobilität and my treating doctors and medical providers can use and hand on all information from my patient documentation (i.e. information about my condition at the time of the treatment, the history of an illness, the diagnosis, the course of the illness, and the type and scope of the extent of the consulting, diagnostic or therapeutic service including the use of medicinal specialties) to other physicians or medical institutions and health care providers (in particular, the referring physician, physiotherapists, laboratories, X-ray institutes, health insurance companies).

In addition, I agree that ZFM – Zentrum für Mobilität and the doctors and health care providers working within it may request this information from all physicians or health care providers.

The information may be disclosed and requested solely for the purpose of my treatment.

I can revoke this consent at any time by sending a postal letter to the ZFM – Zentrum für Mobilität or to the physicians and medical service providers treating me, Argentinierstraße 71/14, 1040 Wien or by e-mail to kontakt@zfm.wien. The lawfulness of the processing of my data until the date of the revocation remains unaffected. I have read this information and agree with it.

My data is subject to medical confidentiality and will be treated absolutely confidentially.

_____ _____

Date Signature patient

CONSENT FORM E-MAIL TRANSMISSION FOR PATIENTS

I agree that, until revoked, the ZFM – Zentrum für Mobilität as well as my treating doctors and medical service providers may send all information from my patient documentation (i.e. information about my condition at the time of consultation or treatment, the history of an illness, the diagnosis, the course of the illness, as well as the nature and extent of the consultative, diagnostic or therapeutic service, including the application of drug specialties) to the following email address via encrypted email.

E-Mail: _____

I acknowledge that by transmitting the data via email, (unauthorized) third parties may gain knowledge of the information and that these data can be changed. I am aware that this may lead to the disclosure of my health status.The transfer and request of the information may only take place for the purpose of my treatment.

☐ I agree that the ZFM – Zentrum für Mobilität may contact me by e-mail for advertising and information purposes.

I can withdraw this consent at any time by sending a postal letter to the ZFM – Zentrum für Mobilität as well as to my treating doctors and medical providers, Argentinierstraße 71/14, 1040 Wien or by e-mail to kontakt@zfm.wien. The lawfulness of the processing of my data up to the time of the revocation remains unaffected. I have read this information and agree with it.

_____ _____

Date Signature patient

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DISCLAIMER OF WARRANTY

In connection with the transmission of findings to the doctors and service providers working at the ZFM – Zentrum für Mobilität, it is expressly pointed out that this must be done by the patient personally to the doctor/service provider.

Neither the ZFM - Zentrum für Mobilität GmbH, as an operator of the center, nor the doctors or service providers working in the ZFM - Zentrum für Mobilität (with whom an implied treatment contract has been conducted) take responsibility or liability for clinical findings that have been transmitted in another way than directly to the doctor/service provider in the course of an appointment.

In this respect, the ZFM - Zentrum für Mobilität GmbH or the doctors and service providers working at the ZFM - Zentrum für Mobilität cannot be held responsible for any damages resulting from the transfer of findings during a meeting with the doctor/service provider. I have read this information and agree with it.

Date

Signature patient

Please note the following page

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