ÄRZTEKASSE
CAISSE DES MÉDECINS
CASSA DEI MEDICI

Logo or stamp of practice / physician

English / Englisch / Anglais / Inglese

Patient form with declaration of consent under data protection law

Name, First name | Name, Vorname | Nom, Prénom | Cognome, Nome

Date of Birth | Geburtsdatum
Date de naissance | Data di nascita

Gender | Geschlecht
Sexe | Sesso
F M

Maiden name | Ledigname | Nom de jeune fille | Cognome da nubile

Marital Status | Zivilstand | Etat-civil | Stato civile

Address | Adresse | Adresse | Indirizzo

Private phone | Tel. privat | Tél. privé | Tel. privato

Zip code, City | PLZ, Wohnort | NPA, Localité | NPA, Località

Mobile

Nationality | Nationalität | Nationalité | Nazionalità

Professional phone | Tel. Geschäft | Tél. professionnel | Tel. ufficio

Occupation, Employer | Beruf, Arbeitgeberin / Arbeitgeber
Profession, Employeur | Professione, Datore di lavoro

E-Mail

Referring / family physician | Zuweisende/r Ärztin / Arzt, Hausärztin/-arzt
Médecin traitant | Medico curante

AVS no. | AHV-Nr. | Nº AVS | No AVS

Health insurance / Insurance / Accident insurance | Krankenkasse / Versicherung / Unfallversicherung | Caisse maladie / Assurance / Assurance accidents | Cassa malati / Assicurazione / Assicurazione infortuni

Type of insurance (MC, general practitioner model) | Versicherungsart (MC, Hausarztmodell) | Type d'assurance (MC, modèle du médecin de famille)
Tipo di assicurazione (MC modello del medico di famiglia)

Insurance card no. | Versichertenkarten-Nr.
Nº de carte d'assuré·e | No tessera d'assicuratio

Supplementary insurance | Zusatzversicherung
Assurance complémentaire | Assicurazione complementare

Billing address (if not identical to address) | Rechnungsadresse (wenn nicht identisch mit der Adresse)
Adresse de facturation (si différente de l'adresse) | Indirizzo di fatturazione (se diverso dall'indirizzo)

Person to be notified, if necessary (name, phone) | Person, die im Notfall zu benachrichtigen ist (Name, Tel.)
Personne à prévenir en cas de nécessité (nom, tél.) | Persona da avvertire in caso di necessità (cognome, tel.)

Representation | Vertretung | Représentation | Rappresentanza

Please fill in if given and not identical with above personal data | Bitte ausfüllen sofern gegeben und nicht identisch mit obigen Personalien
À compléter si nécessaire et si elles ne sont pas identiques aux données personnelles ci-dessus | Si prega di compilare se i dati sono stati forniti e non coincidono con i dati personali di cui sopra

☐ **Legal representative** | Gesetzlicher Vertreter
Représentant légal | Rappresentante legale

☐ **Guardian / Advocate** | Vormund / Beistand
Tuteur / curateur | Tutore / Avvocato

☐ **Power of attorney** | Vollmacht | Procuration | Procura

☐ **Parents** | Eltern | Parents | Genitori

Institution | Institution | Institution | Istituzione

First name | Vorname | Prénom | Nome

Name | Name | Nom | Cognome

Address | Adresse | Adresse | Indirizzo

Zip code, City | PLZ, Wohnort | NPA, Localité | NPA, Località

Mobile

E-Mail

The Data Protection Act stipulates that the patient's specific consent must be obtained to the processing of her/his healthcare data. In order to satisfy that legal requirement, you must confirm the following consent by signing it.

Signature | Unterschrift | Signature | Firma _____

I specifically confirm my consent to the processing of my data, access to that data by the aforementioned physician or therapist and in the practice and disclosure of such data to the following recipients.

Data category	Data processing	Recipients	Purpose
Laboratory data	Patient data, together with blood, urine, stool, microbiology, histology	Laboratory, other physicians, therapists, hospitals	Investigations and medical processing, incl. analysis
Findings	Examination findings and case history	Other physicians, therapists, hospitals and healthcare professionals and establishments, pharmacies (ePrescription)	Targeted information for efficient further investigation / treatment
Patient data	Diagnosis & treatment data	Other physicians, therapists, pharmacies (incl. ePrescription) internally within the practice and managed care systems as well as billing service providers	Documentation, billing
Master data and treatment data	Data for attribution, treatment and billing	Billing service providers, insurers	Processing for billing
Billing and settlement and invoice data	Billing of treatment and medical services, reminders and other bill processing	Ärztekasse Genossenschaft and debt collection agency chosen by the practice, together with chosen software or practice information providers and IT support	Settlement based on legal and contractual criteria and for IT development and creditworthiness checks
Treatment and settlement data	In principle, anonymised or pseudonymized data	Public registers, statistical authorities as well as Trust Centers and FMH (Swiss Medical Association), physicians' societies	Legal requirement to make entries, tariff negotiations / model calculations
Financial and billing data	Data for invoicing and orderly bookkeeping	Bookkeeping and settlement service providers	Invoicing and keeping accounts

Data disclosure
I am aware of the potential risks of exchanging personal data that requires special protection (possible access by unauthorized third parties if communication channels are not secure) and of my rights and I consent to mutual contact between my physician or my therapist and myself as a patient by the sources of information listed above. I also authorize my treating physician or therapist to obtain medical records and documents about me from other physicians and hospitals. This also applies to data exchange within the practice and to representatives. I likewise give my consent to the use of QR codes and to prescriptions or medical certificates with a digital or electronic signature. In principle, my data will be stored solely in Switzerland by the Ärztekasse Genossenschaft for the core applications. For creditworthiness checks, my personal data may be transferred to the Inkasso Med AG / Intrum AG debt collection agency and stored by them if this is required by the treating service provider.

Bill processing
The Swiss Federal Health Insurance Act (KVG) stipulates that patients shall receive a copy of the physician's invoice. By signing this form, I accept potential billing either on paper or electronically by the tiers payant (direct billing to the health insurance scheme) procedure. To simplify the procedure, a copy of the invoice (tiers payant only) is sent to the email address indicated by me, in which case, for ease of understanding, the name of my physician or therapist or practice will be indicated to me in the email. I agree that such copies and also administrative matters such as appointment changes may be notified via my stated email address (@hin address to recipient's address, e.g. @bluewin.ch, @gmail.com etc.).

Payment arrears
If I fail to make a payment by the due date or do not register a reasoned objection, I will be deemed to be in arrears on the expiry of this time limit with no further reminder. The service provider may retain third parties at any time for debt collection purposes. I will bear the costs of payment arrears. Details of the charges made in the event of late payment can be found at the following link: *www.aerztekasse.ch/patienteninfo/faq*.

Based on the above information and on any further verbal explanations, by appending my signature I consent to the processing and transfer of my personal data in compliance with data protection requirements. In addition, I am aware that my consent may be withdrawn in whole or in part at any time without affecting the lawful nature of processing based on my consent until the completion of my withdrawal of that consent. Such withdrawal must in every case be notified in writing. In addition, my request for erasure will not necessarily be followed by erasure because the healthcare professional or practice responsible may be required by law to retain my data. That is why the request for erasure is only followed in justified exceptional cases by a confirmed decision to erase my data held by the healthcare professional or practice who or which is treating me. At the same time, I hereby release my treating healthcare professional in any such case from the legal obligation of retention. The data are retained in principle for 20 years; unless specifically stipulated otherwise by the patient, the medical records may also be retained for longer.

Appointments that are not cancelled in advance may be charged to you. We kindly ask you to inform us in good time.

☐ I have been informed that the additional document entitled "Information for patients about the use of personal data" has been made available to me.

Date | Datum | Date | Data

Signature | Unterschrift | Signature | Firma