MEDICAL TREATMENT CONTRACT

Between

Dr. Dr. med. Thomas M. A. Beck, MD

And

…….. …… ……
Title Surname First name

Adress ……
Street ZIP code city country

Telephone ……

Mail ……

Date of birth: ……

I herewith apply for a medical examination, the recommended therapy and the invoicing according to the scale of fees for medical doctors "Gebührenordnung für Ärzte (GOÄ)" by Dr. Dr. med. Thomas Beck, or his medical representative(s), for the entire treatment period, or at least until the end of the year (whichever applies first). Copies of the medical scale of fees can be obtained at reception.

I agree on receiving an invoice according to the medical scale of fees, in accordance to §§ 1 – 12, excluding §2. I agree that the invoice has to be paid to Dr. Dr. med. Thomas Beck, MD directly or to the medical clearing office. I confirm to pay the entire invoice amount without any deduction or discount, regardless of the reimbursement by the insurance

Based on the terms and conditions (T&C's) of the scale of fees for medical doctors, the invoice is immediately due upon receipt.

Munich, Germany …….. ……
Date Signature of the patient