INFORMATION ON DATA PROTECTION

Dear Patient,

The protection of your personal data is important to us. In accordance with the EU General Data Protection Regulation (GDPR), we are required to inform you about the purpose for which our practice collects, stores, or transfers data. This information also outlines your rights regarding data protection.

1. RESPONSIBILITY FOR DATA PROCESSING

The entity responsible for data processing is:

Practice Name:	Rückenzentrum Am Markgrafenpark GmbH
Address (Street, House Number, Postal Code, City):	Markgrafenstr. 19, 10969 Berlin
Contact Information (e.g., Phone, Email):	Phone: 030-25 92 38 6 0 E-Mail: berlin@ruecken-zentrum.de

You can reach the Data Protection Officer at:

Name:	Mprotect365 GmbH
Contact Person:	Marcel Felgenhauer
Address:	Nordstraße 17-21, 04105 Leipzig
Contact Information (Email):	datenschutz-berlin-mitte@ruecken-zentrum.de

2. PURPOSE OF DATA PROCESSING

Data processing is carried out based on legal requirements to fulfill the treatment contract between you and your doctor and the associated obligations. For this purpose, we process your personal data, particularly your health data. This includes medical histories, diagnoses, treatment recommendations, and findings collected by us or other physicians. Other doctors or psychotherapists involved in your treatment may also provide us with data (e.g., in medical reports). The collection of health data is essential for your treatment. If the necessary information is not provided, proper treatment cannot be ensured.

3. RECIPIENTS OF YOUR DATA

Recipients of your personal data may include, in particular, other doctors/psychotherapists, statutory health insurance associations, health insurance companies, the Medical Service of the Health Insurance Funds, medical associations, law firms, debt collection agencies, and private medical billing centers. The transfer primarily serves the purpose of billing for the services provided to you and clarifying medical questions and questions arising from your insurance relationship. In individual cases, data may be transferred to other authorized recipients.

4. STORAGE OF YOUR DATA

We retain your personal data only as long as necessary for your treatment. Legal regulations require us to store this data for at least 10 years after the conclusion of treatment. Other regulations may impose longer retention periods, such as 30 years for X-ray records according to Section 28 (3) of the X-ray Ordinance. After 30 years, your data will be locked in the medical software.

5. YOUR RIGHTS

You have the right to access information about your personal data. You may also request the correction of incorrect data. Under certain conditions, you have the right to request the deletion of your data, the restriction of data processing, and data portability.
The processing of your data is based on legal regulations. In exceptional cases where your consent is required, you have the right to withdraw your consent for future processing.
Additionally, if you believe that the processing of your personal data is not lawful, you have the right to file a complaint with the relevant data protection supervisory authority.
The contact details of the competent supervisory authority for us are:

Name:	Berliner Beauftragte für Datenschutz und Informationsfreiheit
Adresse:	Friedrichstrasse 219, 10969 Berlin

6. LEGAL BASIS

The legal basis for processing your data is Article 9 (2) (h) GDPR in conjunction with Section 22 (1) No. 1 (b) of the German Federal Data Protection Act (BDSG). If you have any questions, please feel free to contact us.

Further information on data protection can be found on our website:
https://ruecken-zentrum.de/datenschutz

Information on Data Processing and Confidentiality

Dear Patient,

Welcome! We are pleased that you have chosen to receive treatment with us. Under the umbrella of our facilities, doctors, psychologists, physiotherapists, and sports scientists work together as a team to ensure your well-being and long-term health.

Our approach is based on interdisciplinary medicine that focuses on the whole person and is rooted in the latest scientific findings. Depending on your needs and in consultation with you, examinations and treatments may be conducted by a specialist in orthopedics, a specialist in physical and rehabilitative medicine, physiotherapists, sports therapists, or psychologists, either individually or as a team. This interdisciplinary collaboration guarantees a safe and efficient treatment process. Even in individual treatments, every therapist is capable of incorporating the insights of their colleagues into your therapy. The interdisciplinary therapy provided within our facilities is carried out by various therapeutic units, which, for organizational reasons, may operate as legally independent natural and legal entities under the umbrella of our facilities. These include:

1. Spine Center Markgrafenpark, Markgrafenstr. 19, 10969 Berlin, consisting of: Rückenzentrum Am Markgrafenpark GmbH, Orthopaedic Practice Dr. Marnitz, Practice for Physical and Rehabilitative Medicine Bianka Klein, Practice for Psychotherapy Am Markgrafenpark GbR Dorothee Monstadt, Christine Michel, Dr Marion Heinrich,
2. Spine Center Köpenick, Freiheit 1, 12555 Berlin, consisting of: Gelenk- & Rückenzentrum Köpenick GmbH,
3. Spine Center Hamburg, Ludwig-Erhard-Straße 18, 20459 Hamburg, consisting of: Rückenzentrum Am Michel Prävention GmbH, Orthopaedic practice Dr. Mallwitz, Practice for PRM; Physiotherapie Am Michel, Erste-Brunnen-Str. 1, 20459 Hamburg.

(hereinafter referred to as: facilities). To enable interdisciplinary therapy within these facilities, all doctors, therapists, medical assistants, reception staff, and administrative employees involved in your therapy (hereinafter referred to as: employees) must collect, process, and use your data to the extent necessary. In particular, the involved employees must exchange data among themselves to ensure that all relevant staff members are fully informed about your treatment and can provide you with the best possible care. Depending on the therapy, the collection, processing, and use of general personal data (such as name, address, date of birth, insurance details, bank details) as well as special categories of personal data related to your health (such as treatment records and medical findings) may be required.

For the aforementioned collection, processing, and use of data, we require your consent as a patient. If medical confidentiality applies, we also require a release from this confidentiality obligation. We kindly ask you to provide these declarations on the following form.

This consent only applies to the above-mentioned facilities and does not extend to third parties. All employees of these facilities are contractually bound to data confidentiality (GDPR) and are additionally subject to medical confidentiality under Section 203 of the German Criminal Code (StGB).

Your consent is voluntary and can be revoked at any time with future effect. However, if you choose not to give consent, we will be unable to admit or treat you at our facilities.

If you have any further questions, please feel free to contact our staff. We wish you a pleasant stay with us and a speedy recovery.
– Your Practice Team

Consent to Data Processing and Confidentiality Waiver

Name and Address of the Patient (hereinafter referred to as: Patient)

I have read and understood the above information on data processing and confidentiality. For the purpose of interdisciplinary therapy, I release the mentioned facilities and their employees from medical confidentiality with respect to one another.

I also consent to the collection, processing, and use of my general personal data (including name, address, date of birth, insurance details, bank details) as well as health-related data (including treatment records and medical findings) as special categories of personal data by the aforementioned facilities and their employees for the purpose of interdisciplinary therapy. The facilities and their employees are authorized to exchange the aforementioned data among themselves as necessary.

Place, Date	Signature (for minors, signature of the legal guardian)

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First Name:	Last Name:
Birth Name:	Birthday:
Postal Code / City:	Street:
Private Phone:	Business Phone:
Mobile Number:	Occupation:
Name, Address, and Phone Number of the Referring Physician:	
Name of Your Health Insurance Provider:	Entitled to Benefits: Yes ____%
Family Insured Through:	
Name:	First Name:
Address:	

I have been informed that I will receive a private invoice for the medical services provided, in accordance with the official Fee Schedule for Physicians (GOÄ) pursuant to §§ 1-12. I am fully responsible for the payment of this invoice(s), regardless of any potential reimbursement from my health insurance provider. The opportunity to review the GOÄ was available.

Please note that if you are insured under a Post B, student private insurance, standard, or basic tariff, your health insurance provider may not reimburse the services invoiced, as this practice operates exclusively as a private medical practice.

Berlin, ...

.....

Signat*ur*e of the Patient

Patient consent form for email correspondence

From: _____
Name, First Name, Address

Für:

X	Rückenzentrum Am Markgrafenpark GmbH Markgrafenstrasse 19, 10969 Berlin (Tagesklinik, Physiotherapie, Psychologie, Prävention)
X	Praxis für Orthopädie & Unfallchirurgie Dr. Ulf Marnitz Markgrafenstrasse 19, 10969 Berlin
X	Praxis für Physikalische und Rehabilitative Medizin Bianka Klein Markgrafenstrasse 19, 10969 Berlin
X	Psychologie Am Markgrafenpark GbR D. Monstadt – C. Michel – Dr. M. Heinrich Markgrafenstrasse 19, 10969 Berlin

I agree that, if I am a patient (m/f/d) at the above-mentioned companies, they may respond to my inquiry via unencrypted email to the email address provided here:

_____

I may also receive information about appointments and/or invitations to participate in a program via email. I am permitted to be contacted with follow-up questions regarding my therapy.

I further agree that my medical reports, medical findings, invoices, and prescriptions may be sent to my above-mentioned email address in **password-protected format**. I understand that encrypted documents must be opened with the password (my postal code) and then saved as a new PDF document on my computer before they can be uploaded digitally, for example, to the health insurance portal.

Information on Digital Billing and Storage of Physiotherapy Prescriptions and Emails
Your doctor's prescription (physiotherapy prescription) will be scanned and stored in your digital patient file at the Back Center Am Markgrafenpark. The original paper copy will then be securely destroyed in accordance with data protection regulations. The electronic version will be stored securely for at least ten years. Access is restricted to authorized staff. This ensures the full processing of your treatment and billing with your health insurance provider.

Emails will not be forwarded to third parties. Your consent is voluntary. Refusal or withdrawal of consent will not result in any disadvantages for you. You have the right to withdraw your consent to the processing of your email address at any time in accordance with Article 21 Paragraph 4 of the GDPR and to request that it no longer be processed. To do so, please send an email to: Berlin@ruecken-zentrum.de or a letter to Praxis Orthopädie Dr. Ulf Marnitz, Markgrafenstrasse 19, 10969 Berlin. The lawfulness of the data processing carried out based on your consent before its withdrawal remains unaffected.

Date and Patient's Signature_____

_____

or

□ No, I do not consent and wish to receive everything by post.

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Consent for the Medical Treatment (E1)

Dear Mrs./Mr._____

Our medical treatment consists of measures that require your consent. These include, among others, manual medical / chiropractic techniques, medication administration and injections with or without X-rays. The selection of these measures is tailored toward your illness and will be discussed with you in advance. All measures can cause undesirable effects, which in most cases are not dangerous when recognized on time.

The chiropractic treatments on the extremities can cause symptoms similar to muscle ache. At this time no serious consequences are known. In extremely rare cases serious complications may occur during the course of treating the spinal areas (f.e. damage or aggravation of the nerves). Even more rare are cases in which arteries that supply the brain are damaged (1:400,000-1:2Mill Cases). We only recommend manual medical treatment, if the expected therapeutic success clearly outweighs the risks.

In addition to the chiropractic treatment we employ Therapeutic Local Anesthesia (TLA) for pain relief and muscle relaxation. If needed, the injection treatment is administered under X-ray and after contrast-fluid display of the structure to be treated. After injections or punctures (suction of fluids) small bleedings or nerve irritations can occur. Occasionally infections of a joint or of tissues in the surrounding area of the puncture happen despite correct techniques, but they are extremely rare (ca. 1: 30,000 cases). All medications (injections, pills) can cause allergic reactions.

Should you notice after an injection fever, redness or swelling in the treated region or on your whole body, please inform us immediately, or call the medical emergency room or go to the central admission of a hospital.

We are happy to answer further questions.

Statement of patient:

I was sufficiently informed about the treatment methods recommended to me, and about their possible, undesirable side-effects.

I declare that at this time I do not take blood thinning medications (f.e. Macumar).

I agree to the treatment.

Berlin, _____

....
Treating physician's signature Patient signature

....
Print Patient's last and first name Patient Number

I received a copy of this agreement.

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Patient Questionnaire

Excerpt from the pain questionnaire of the DGSS (German Pain Association) work group “Documentation”

Dear Patient,

First we like to know how you became aware of us:

- Your orthopedic doctor
- Media
- Mediplex
- Your family doctor
- Internet
- Personal recommendation
- Other

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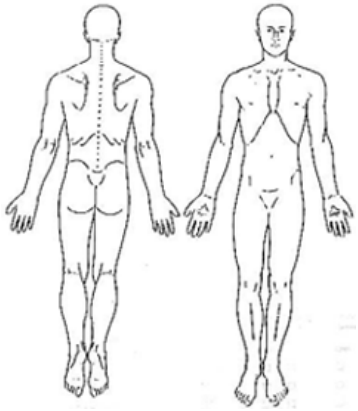
The following questions relate to your person and your history of illness. Together with existing medical reports and findings they provide clarification and make it easier for us to plan your further diagnoses and treatment. It therefore lies in your best interest to give a thorough and complete response to all questions. All the data of this questionnaire are protected by patient-physician confidentiality and fall under the regulations of the Federal Data Protection Law.

Name.....

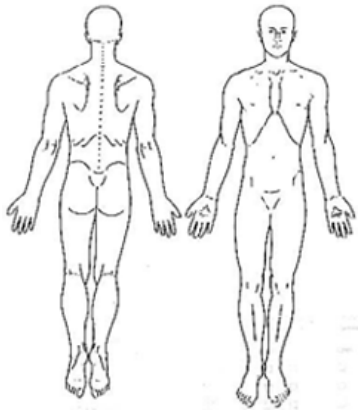
Date.....

1. In the following body sketches, please pencil in where you have pains. Indicate the total region of your pain (with pencil or pen). In both sketches to the left indicate where your major pains occur, in both schemes to the right indicate where else you have pains.

Major Pain Area



Other Pain Areas



2. When did your major pain generally begin? _____

3. When did your current pain episode begin? _____

4. In the following please rate the degree of your pain. Please circle how strongly you feel your pain. A value of 0 means that you have no pain at all, while the value of 10 means that you suffer from such great pain that you cannot imagine it being any stronger.

a) Indicate your average strength of pain during the past 4 weeks:

[0] [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

no pain — strongest imaginable pain

b) Indicate what strength of pain you would find bearable with successful treatment:

[0] [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

no pain — strongest imaginable pain

5. What type of exercise or physical activity do you perform on a regular basis?

Type of Exercise	Frequency

6. Are you a member of a club or fitness studio? (Check one.)

No ___ Yes ___ at _____

Name of club or fitness studio

7. Have you undergone surgery because of your pain? No ___ Yes ___

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Type of surgery: Date

1. _____ _____
2. _____ _____
3. _____ _____

If more than 3 pain surgeries, number of times operated: _____ .

Print Patient's last and first name

8. Have you undergone any other than pain-related surgeries?

No ___ Yes ___

Type of surgery: Date:

4. _____ _____
5. _____ _____
6. _____ _____

9. If possible, list all medications that you have taken in the past six months. Also, indicate whether you take the medication regularly (e.g. 3x1 tablets) or only "if needed". Please especially consider blood thinning drugs (e.g. Aspirin, Heparin) and immune suppressing medications (f.e. Cortison, psychotropic drugs, hormonal drugs, osteoporosis drugs).

During the past 6 months I have taken the following medications:

Medication	Type (tablets, suppositories, drops)	Dose	Time period
Example: Paracetamol	Tablets 500mg	3x1 a day	Jan.- Mar. 2012

10. Has your weight weight changed drastically in the past months? No ❑
11.
    - Yes, in the past ____ months, I have lost _____ kg weight
    - Yes, in the last ____ months, I have gained _____ kg weight.

12. Did you have a more serious infection in the past months?

Yes _____ No_____

If yes, please describe: _____

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13. Please, provide your body height and weight.

    Height in cm:_____ Weight in kg:_____

14. Do you suffer from symptoms of paralysis or feelings of weakness in your arms and legs or lack of control when emptying stool or bladder?

    Yes ____ No _____

    If yes, please describe briefly:

15. Are you aware of any allergies or problems with your digestion?

    _____

    _____

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16. Please, tell us what treatment you have received so far for your major pains. Please, let us know the time period in which you were last treated and whether the treatment has helped. You can mark a cross at several places.

Therapy	Time Period (year, and if so, month)	Good Relief	Little Relief	Short Relief	Same	Worse
Injections, local injections		❑	❑	❑	❑	❑
Setting of joints, Chiropractic therapy		❑	❑	❑	❑	❑
Physical Therapy		❑	❑	❑	❑	❑
Training Therapy		❑	❑	❑	❑	❑
Massage		❑	❑	❑	❑	❑
Bed Rest		❑	❑	❑	❑	❑
Warmth, Fango (Mud Therapy)		❑	❑	❑	❑	❑
Cold Application		❑	❑	❑	❑	❑
TENS Machines		❑	❑	❑	❑	❑
Acupuncture		❑	❑	❑	❑	❑
Corset		❑	❑	❑	❑	❑
Pain Medication		❑	❑	❑	❑	❑
Outpatient Rehab		❑	❑	❑	❑	❑
Surgery		❑	❑	❑	❑	❑
Pain Clinic		❑	❑	❑	❑	❑
Inpatient, Rehab, Resort		❑	❑	❑	❑	❑
PRT's (Periradikuläre Therapie)		❑	❑	❑	❑	❑
Other…		❑	❑	❑	❑	❑

17. Have you suffered serious illnesses as an adult?

Please, mark the box that applies to you. Below this list you can give an explanation.

1. Heart Disease
   Yes ❑ No ❑
2. Circulation Disease
   Yes ❑ No ❑
3. Malignant Disease (tumors)
   Yes ❑ No ❑
4. Disease of Nervous System (Seizures)
   Yes ❑ No ❑
5. Metabolism Disease
   Yes ❑ No ❑
6. Lung Disease
   Yes ❑ No ❑
7. Stomach – Intestines – Colon Disease
   Yes ❑ No ❑
8. Urinal tract Disease
   Yes ❑ No ❑
9. Liver -, Pancreas-, Gallbladder Problems
   Yes ❑ No ❑
10. Sickness of the abdomen – /sexual organs
    Yes ❑ No ❑

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Explanations of points 1-10: Regarding point ____:

_____

_____

What sickness, since what year? _____

Thank you for your cooperation!

Information for Patients with Back Problems:
Interdisciplinary Therapy Management at the Back Center at Markgrafenpark---Day Clinic

Dear Patient,

You chose our "Back Center at Markgrafenpark" for an examination and/or therapy of your back problems.

In recent years, back problems have steadily increased, even though tremendous progress has been made in the clinical diagnostics, surgical and non-surgical treatment methods. The topic of "back pains" meanwhile has become the object of intense scientific research worldwide. There is a consensus that "back pains" are a multi-layered problem. From the international research of the past years a multitude of guidelines have been developed and are being updated continuously.

Our total concept does not only orient itself at the specific guidelines currently in effect, but the Back Center is also represented on the board of directors of the Guideline Commission of the European Union. For your better understanding we like to inform you briefly about our interdisciplinary therapy management:

In search of a diagnosis: Disrupted structure or disrupted function?

From your own experience you are probably aware that back pain can express itself in very different ways. When you visit an orthopedic doctor, you justifiably expect primarily a clarification of the physical causes of your back pain. It's up to the physician to decide, whether you have a specific structural problem (e.g., a nerve root irritation, a broken vertebra, or an infection), or whether you are dealing with a so-called functional problem. The latter means that the spine didn't suffer serious "damage", but that it simply doesn't function well in terms of resilience and/or flexibility. Functional problems are (fortunately!) the most frequent cause of back problems. Be happy when the physician explains your problem as a functional one: you can be sure that then the physician was able to out rule every possible serious disease. Additional good news: functional disorders can be treated very well and often with astonishingly simple means, and you yourself can play an active role!

The duration: how long is the back "allowed" to hurt?

Beyond knowing the cause of your spine problem it is important for you to know that acute episodes of back pain run through a certain "normal" course of time. For almost every affected structure in the musculoskeletal system (muscles, joints, nerves, among others). That means that even if your back suddenly hurts vehemently, and if you have the feeling that you absolutely cannot move nor endure any pressure, in many cases these pains will subside within a time period of four up to maximal eight weeks, until you can pick up your normal physical activities without special restrictions. We attempt to influence this process through medical and therapeutic means in a positive way. As soon as we find during the therapeutic process that in the expected "recovery time" there is no obvious improvement or even a further deterioration of your problems, of course, we will assess all previous medical and therapeutic strategies and possibly modify them. It is the great advantage of this center that all the involved disciplines work under one roof. Therefore we are able to react quickly within your treatment team and guaranty a seamless therapy.

Psychosocial Factors – what can influence the spine problem?

All current international guidelines recommend the holistic view of the pain process for the diagnostics. Included here are the so-called "psychosocial stress factors". Unfortunately we are still facing much skepticism when including these factors in the assessment and therapy of your back problem. We define "psychosocial factors" as fears and insecurities due to deficient and flawed information about your back problem, but also as a sense of helplessness and despair resulting from longer lasting back pains and the often significant restrictions in the everyday private and work life. Stress at work, problems in your relationships/family or financial worries and fears for the future can also produce possible psychosocial burdens. As it is with every "healthy" person, these burdens can impact our general wellbeing (f.e. inner tensions, lack of vitality, brooding).

Psychosocial stress factors can have a negative effect on the perception of pain and may delay a clear improvement within the physiological time frame.

A contribution of these factors does <u>not</u> mean that your pain is only "in your head" and that you don't have a physical problem – this is often misunderstood! Rather, it means that these factors can prolong or prevent the diminishing of your physical discomfort (in the adequate physiological time frame).

Our psychologists are specialized in psychological pain therapy and will advise you individually on what strategies might be helpful to positively influence the pain process also in this regard.

We hope that in this brief overview over we could clarify the opportunities of an interdisciplinary diagnostic/therapy for your back problem!

Your Team at Markgrafenpark!