OSTEOPATHIE
SABRINA
SCHAFFITZEL

OSTEOPATHIC TREATMENT AGREEMENT

Agreement Between:

Osteopathy Practice Sabrina Schaffitzel, Naumburger Str. 28, 04229 Leipzig

and

Patient Information:

Name:	
Date of Birth:	
Address:	
Postal Code:	
Phone Number:	
Email Address:	

I. Subject of Agreement

This agreement pertains to the osteopathic therapy treatment provided to the patient. The treatment may include both conventional and alternative therapeutic approaches, some of which may not be recognized by mainstream medical science. This agreement constitutes a treatment contract in accordance with Section 630a et seq. BGB in conjunction with Section 611 BGB. It is established when the patient signs this contract or otherwise accepts the services of the practice informally.

II. Fees

The fee for a healing treatment is agreed to be between €95 and €140, regardless of the length of the treatment.The duration of the treatment depends on the course of treatment. The treatment also includes the anamnesis interview withthe patient.

Fees are due immediately upon invoicing and must be paid within 14 days. If payment is delayed, the patient will incur a late fee of €5.00. If additional reminders are necessary, an additional late fee of €10.00 will be charged.

III. Important Information

Appointment Scheduling and Cancellations

The practice operates by appointment only, meaning that each scheduled session is exclusively reserved for the patient. The patient agrees to:

- Arrive on time for appointments.
- **For cancellations up to 48 hours before the scheduled appointment, 50% of the cost will be charged. For cancellations within 24 hours of the confirmed appointment, 100% of the cost will be charged.**
- To cancel an appointment, the patient may call 0178 51 78 109 (voicemail is available) or email info@osteopathie-schaffitzel.de

Missed or late-canceled appointments (less than 24 hours in advance) will be charged the full session fee.

No Guarantee of Healing

There is no guarantee of healing or symptom relief associated with any treatment. In accordance with the German Advertising of Medicines Act (HWG), no promises regarding treatment outcomes are made.

Treatment Disclaimer

The patient acknowledges that osteopathic therapy does not replace medical treatment by a licensed physician. If medical attention is necessary, the therapist will recommend seeking medical care or refer the patient to a qualified physician. This also applies in cases where legal restrictions prevent the therapist from providing treatment.

Confidentiality

All information shared during treatment is confidential. The therapist is bound by confidentiality laws and will not disclose any details to third parties. However, in certain circumstances—such as a reporting obligation under the German Infection Protection Act (IfSG) or a court order—the therapist may be legally required to breach confidentiality.

Data Protection

The practice stores personal data only to the extent necessary for diagnosis, treatment, and contract fulfillment. Data processing follows the regulations outlined in the German Federal Data Protection Act (BDSG) and the General Data Protection Regulation (GDPR).

IV. Billing for Osteopathic Services

Billing is conducted in accordance with the Fee Schedule for Alternative Practitioners (GebüH).This treatment agreement exists independent of the patient's insurance coverage, and the patient is responsible for settling all fees regardless of whether their insurance provides reimbursement.

Acknowledgment and Agreement:

Leipzig, Date: _____

Patient’s Name & Signature: _____

The patient may revoke consent at any time and terminate the treatment. Additionally, they may request the presence of a trusted person during the session if desired

INFORMED CONSENT

Patient Name: _____

Please review the information below. The consent form will be signed **on the day of the treatment** after discussion with the therapist.

What is Osteopathy?

Osteopathy is a specialized form of manual medicine focused on identifying and treating functional disorders and their underlying causes. Treatment is performed exclusively using hands-on techniques. Osteopathy considers the entire body when diagnosing and addressing conditions. Before treatment, the therapist conducts a detailed assessment and diagnosis based on the patient's medical history.

Contraindications – When Osteopathy is Not Recommended

A treatment should not begin if there is uncertainty about a diagnosis. Before starting therapy, a thorough medical evaluation is required to ensure that osteopathic treatment will not delay necessary medical interventions.

Osteopathy may be contraindicated in cases of:

- Aneurysms
- Acute infections
- Contagious diseases
- Fever-related conditions
- Bone fractures
- Cancer
- Circulatory disorders in the brain
- Blood disorders
- Thrombosis
- Unexplained spontaneous bruising

It is essential to consult a physician or osteopath to assess whether osteopathic treatment is appropriate or if there are contraindications.

Individual risks

Notes regarding the consent process

Potential Risks of Treatment

- Fatigue, dizziness, headaches, sleep disturbances
- Temporary worsening of symptoms or flare-ups of chronic inflammation
- Soreness similar to muscle fatigue
- Rarely, minor joint or skin discomfort after spinal treatment
- Extremely rare risks (1 in 400,000 to 1 in 2,000,000 cases): brain hemorrhage, spinal cord injury, or stroke

INFORMED CONSENT AGREEMENT OSTEOPATHY TREATMENT

I confirm that Sabrina Schaffitzel has provided a detailed explanation of the planned osteopathic treatment, its potential risks, and possible side effects. I had the opportunity to ask questions, which were answered to my satisfaction.

I understand that I may have a trusted person present during treatment. I have had sufficient time to consider the treatment plan and its implications.

☐ **I voluntarily consent to treatment. I acknowledge that I have been informed of the associated fees and billing policies.**

Date: _____ Patient's Name & Signature: _____

INFORMED CONSENT FOR ADDITIONAL TREATMENT: DRY NEEDLING (optional)

Dry needling is a complementary therapy method in which sterile, disposable acupuncture needles are used to treat myofascial trigger points and fascia. The treatment is performed by appropriately trained specialists in compliance with all safety and hygiene standards.

Possible side effects include local hematomas and a muscle ache-like sensation at the treated site, which may last for several days. In rare cases, dizziness, vegetative symptoms, infections, allergic reactions, nerve irritation, vascular injuries, or—very rarely—injuries to internal structures may occur.

☐ I **confirm that I have been informed about the significance and possible risks of dry needling treatment and agree to its performance.**

Date: _____ Patient's Name & Signature: _____

Signature therapist Sabrina Schaffitzel: _____

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GENERAL ANAMNESIS FORM

Providing this information is voluntary: You are not required to answer all questions.

Personal Information

Name, First Name:

Date of Birth:

Occupation:

Height, Weight:

For women of childbearing age: Are you currently pregnant? If so, what month?

Current Complaints

What are your current complaints?	Have you experienced paralysis in your arms or legs?	How long have you been experiencing these complaints?	Please describe the pain in detail.	What triggers/reliefs the pain?

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Medical History

Have you received any medical diagnoses? If yes, please define.

Have any preliminary examinations been conducted (e.g., CT, MRI, X-rays)? If yes, please define and bring images to treatment if possible.

Have you had any laboratory tests (e.g., blood tests, urinalysis)? What has been the results?

Surgeries, Fractures, and Accidents: (Check if applicable and provide additional details)

☐ Appendix removed

☐ Tonsils removed

☐ Gallbladder removed

☐ Bone fractures (please specify):

☐ Accidents, whiplash injuries (please specify):

Osteopathic Treatment History:

Have you had osteopathic treatment before? YES/NO

Did you experience any issues during treatment? YES/NO

Anamnesis

Do you suffer from any of the following conditions? (Check all that apply)

☐ Headaches?

☐ Migraines?

☐ Visual disturbances?

☐ Swallowing difficulties?

☐ Jaw (TMJ) problems, dental issues?

☐ Wore braces as a child?

☐ Dizziness?

☐ Tinnitus?

- If yes, does it coincide with your pulse?
- Is it unilateral or bilateral?

☐ Chest pain, breathing difficulties, lung diseases (e.g., tuberculosis, asthma, pneumonia, chronic bronchitis)?

- If yes, please specify:

☐ Heart disease, congenital heart defects?

☐ Vascular diseases

- In case of high blood pressure, which values?

☐ Digestive issues?

☐ Irregular bowel movements? I

- f yes, how often, what color and consistency?

☐ Stomach disease? Bowel disease?

☐ Have you had a colonoscopy?

☐ Pancreatic disease (e.g., diabetes mellitus)?

☐ Kidney disease?

☐ Liver disease?

☐ Red discoloration of urine?

☐ Connective tissue disorder (e.g., Marfan syndrome, Ehlers-Danlos syndrome)? Allergies (please specify):

☐ Neurological conditions (e.g., epilepsy, paralysis)?

☐ Skin diseases?

☐ Thyroid disorders?

☐ Metabolic disorders (e.g., rheumatism, gout)?

☐ Cancer?

☐ Mental health conditions?

☐ Other underlying or acute conditions unrelated to the reason for your visit (please specify):

Medications

Are you currently taking any medications? If so, please list them:

Name	Dosage

Lifestyle Habits and Recent Changes

Have you experienced changes in hunger, thirst, or digestion in the past year? If so, please specify.

Do you smoke? YES/NO

- If yes, how much?

Do you consume alcohol? YES/NO

- If yes, how much?

Do you experience a high level of stress? YES/NO

Do you exercise regularly? YES/NO

How is your sleep quality? Good/Bad , or describe in your own words.

Family Medical History

Check all conditions that apply to family members:

☐ High blood pressure

☐ Diabetes

☐ Heart attack

☐ Stroke

☐ Lipid metabolism disorder

☐ Asthma

☐ Cancer

☐ Thrombosis

☐ Other (please specify)

Acknowledgment:

Leipzig, Date: _____

Signature: _____

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PRIVACY INFORMATION AND CONSENT FORM

1. Responsible Entity:
Osteopathy Practice – Sabrina Schaffitzel, Naumburger Str. 28, 04229 Leipzig

2. Data Protection Officer:
I am not required to appoint a data protection officer.

3.Purpose and Legal Basis for Data Processing:
Your personal data is processed for the following purposes:

A, Execution of the Treatment Contract and Billing:Legal Basis: Consent pursuant to Article 6(1)(a) GDPR and Article 9(2)(a) GDPR concerning health data.

B, Newsletter Distribution: Legal Basis: Consent pursuant to Article 6(1)(a) GDPR (if consent is the legal basis for processing).

C, Processing for Invoicing and Fee Notices via Email: Legal Basis: Article 6(1)(a), (b), (c) GDPR.

4. Types of Personal Data Processed:

The following types of personal data are processed for the purposes outlined above under number 3:

Reg. 3A, For contract execution and invoicing: Health data (treatment history), contact details, and billing data.

Reg. 3B, For newsletters: Name and email address.

Reg. 3C, For invoicing: Name, treatment type, and billing data.

5. Recipients of Personal Data:

Your data will not be shared with third parties unless required by law.

6. Retention Period for Personal Data:

Your data will be retained only for as long as necessary to fulfill the intended purpose.

Data subject to statutory retention obligations cannot be deleted under Article 17(3) GDPR. For example, under Section 630f (3) of the German Civil Code (BGB), medical records must be retained for 10 years after treatment completion.

Additional retention may be required if health data contains critical information of interest to the data subject.

Furthermore, retention may be justified under Article 17(3)(e) GDPR in cases where potential damage claims apply.

7. Your Rights as a Data Subject:

Under GDPR, you have the following rights regarding the processing of your personal data:

- Right to access information about your stored data and its processing (Art. 15 GDPR).

- Right to rectification of inaccurate personal data (Art. 16 GDPR).

- Right to erasure of your data (Art. 17 GDPR).

- Right to restriction of processing, where deletion is not yet possible due to legal obligations (Art. 18 GDPR).

- Right to object to data processing (Art. 21 GDPR).

- Right to data portability, where processing is based on consent or contract (Art. 20 GDPR).

If you have given consent, you may withdraw it at any time with future effect.

If you believe your data has been processed unlawfully, you have the right to file a complaint with the responsible data protection authority (Art. 77 GDPR in conjunction with Section 19 BDSG):

Dr. Juliane Hundert

Postfach 11 01 32, 01330 Dresden

or

Devrientstraße 5, 01067 Dresden

There is no contractual or legal obligation to provide us with your personal data. However, we cannot perform the treatment contract without processing the data mentioned under 3a.

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Consent to Data Processing

Legal Basis: Art. 6(1)(a) GDPR, Art. 9(2)(a) GDPR

I,

First Name: _____

Last Name: _____

Date of Birth: _____

hereby give my consent to:

Osteopathy Practice – Sabrina Schaffitzel, Naumburger Str. 28, 04229 Leipzig

Phone: 0178 51 78 109

for the processing of my personal data, including sensitive health data, for the purposes of:

- Execution of the treatment contract

- Receipt of newsletters

- Processing of invoices and fee notices via email

I understand that I can withdraw my consent in whole or in part at any time without justification, with future effect. The provision of this consent is voluntary. If I do not consent, there will be no disadvantage. However, without consent, the treatment contract cannot be executed.

This does not affect the billing of previously rendered services.

I acknowledge that I have received a copy of the privacy notice for reference.

Date: _____

Signature: _____