MediCoL®

Treatment contract / Intake / anamnesis form

Name ☐mr. ☐mrs.: …… **Initials:** ……..
Maiden name: …… **Usual name** ……..
Address: …….. **Date of birth:** ……
Postal code / domicile: …… **Profession:** ……..
Country……
Phone number home: ……..
Phone number work: ……
Phone (mobile): …….. **Signature:** ……..
Email address: …… **Filled out by:** ……..

01. Do you have children? ☐Yes ☐No
If yes, how many? ……. Are all children in good health? ☐Yes ☐No
If not, why not? ……..
……..
02. How are you insured? ☐Individual ☐Collective Name insurance company: ……
Polis number: …….. Did you effect an additional insurance? ☐Yes ☐No
03. What is your lenght? …….cm. What is your weight? …….. kg
04. Do you take drugs? ☐Yes ☐No
05. Do you take any medication / food supplements at the moment? ☐Yes ☐No
If yes, which (brand / trade name, strenght and dosage). If necessary please proceed on page 3/3).
……..
……..
……..
……..
06. Have you been operated upon? (If necessary please proceed on page 3/3). ☐Yes ☐No
If yes, why and when? ……..
……..
……..
07. Who is your general practitioner? …….. Phone number: ……..
08. Does your GP know about the treatment in our practice? ☐Yes ☐No
09. Are you being treated somewhere else at the moment? ☐Yes ☐No
If yes, whom by and what for? ……..
……..
10. For what complaints and by whom where you treated in the past? ..... ……..
……..
……..
11. What are your main complaints <u>at this very moment</u>? (please state as accurate as you possibly can).
If desired you may give an extensive description on page 3/3.
……..
……..
……..
When did your complaints start? ……..
12. Do you suffer from continuous pain or at (regular) intervals? ☐continuous ☐(regular) intervals
☐different, namely: ……..
13. Were your complaints being caused by an accident? ☐Yes ☐No If yes, date of accident: ……
14. Did you ever suffered from one of the following diseases? ☐Yes ☐No
If yes, please tick box: ☐amoeba dysentery ☐icterus (jaundice) ☐malaria ☐Pfeiffer
☐toxoplasmosis ☐tbc(tuberculosis) ☐tyfus ☐scarlatina
15. Did you suffer from any other disease(s) or complaint(s) worth mentioning? ☐Yes ☐No
If yes, which and when? (If necessary please proceed on page 3/3).
……..
……..
16. Are there recidive complaints within your family? (for instance, cancer, heart- and blood vessel related diseases) If yes, which and whom did it concern? ☐Yes ☐No
……..
……..
17. Do you suffer from allergic reactions? ☐Yes ☐No
If yes, what for? ……..
18. Did you ever consult a ☐psychologist or ☐psychiatrist? ☐Yes ☐No
If yes, what for and for how long a period? ……..
Have the treatments stopped? ☐Yes ☐No
19. Did you smoke or do you still smoke at the moment? ☐Yes ☐no
If yes, how many a day? …… sigarettes/sigars different, namely: ……..
How many years do you smoke? …… years (If you stopped smoking, how long did you smoke? …… years

20. Do you take alcohol? ☐Yes ☐No
    If yes, how much? …. Glasses …… per day / week
    Are you addicted to alcohol, drugs, tobacco and the like? ☐Yes ☐No
21. How did you obtain our address? ☐GP ☐medical specialist ☐(physio)therapist ☐web site
    ☐via acquaintance ☐other, namely: …… ☐Yes ☐No
22. Are you pregnant? (if applicable).
    If you answer this question with 'yes' you cannot be treated by way of precaution! ☐Yes ☐No
23. Do you have a pace-maker or do you suffer from any cardiac affection?
    If you answer this question with 'yes', you cannot be treated! ☐Yes ☐No
24. Do you suffer from hypertension (high blood pressure)? ☐Yes ☐No
25. Do you suffer from hypotension (low blood pressure)? ☐Yes ☐No
26. Are there any sleeping problems?

Important highlights (Read this information carefully before commencing a treatment!)

- With signing this form you herewith declare to have filled out all desired data truthfully and as complete as possible. Furthermore you herewith declare without prejudice to agree with all following highlights(this also expressively includes all eventual after-treatments).
- We cannot possibly give you any guarantees of any kind, w.r.t. eventual recovery! Although we will do our very utmost to improve your health, you must realize that this will not always be the case. If you have any doubts please do not sign this form!
- It is recommended to always inform your general practitioner and or consult your physician w.r.t. a treatment in our practice.
- By signing this form you explicitly declare that you totally agree with the contents of this form and herewith order us to (after)treat you, therefore on a voluntarily basis and without any obligation.
- In all cases Dutch law will be applicable at all times, without any exception.
- The treatment cost with the medicol® formula amount to € 62,50 per day. (the first treatment day will be charged and the last treatment day will not be charged). The cost of an admission interview: € 75,00. The cost of a check up: € 25,00. The cost for a urine test: € 35,00.
- All days the treatment device is (unlawful) in your possession will be charged (Unless otherwise agreed upon).
- We will invoice you periodically (depending on treatment time). The payment instructions as stated on our invoice must be followed precisely. If not, eventual (repeat) treatments can be suspended immediately.
- The invoice price has to be directly remitted to: Brinkenheide b.v. If your insurance company allows you a (partial) compensation you are still urged to pay the invoice amount to Brinkenheide b.v. thirst. Hereafter you can charge your insurance company (if applicable). In case of 'force majeure' or urgent circumstances, we are willing to adjust our terms of payment in mutual consideration. (You must state this beforehand).
- All Medicol® treatment equipment including all Medicol® colour tabs explicitly remain the legal and inalienable property of Brinkenheide b.v., Hessenmeer 80, 3852 NZ Speuld (Ermelo) Netherlands, legally represented by J.W. van den Brink or appointed employee(s) and/or substitute(s), under all possible circumstances.
- All highlights are (without any restriction) applicable on future consults and (future) treatments.
- In case of grave negligence or misbehaviour (of a patient and or accompannion(s), Brinkenheide b.v. can immediately stop the treatment whereas the patient is obliged to pay for the therapy entirely.
- Psychical and/or physical shortcomings cannot be treated; for instance lack of a certain substance or damage caused by, for instance medical surgery, (medical) treatments, medication, drugs, smoking, alcohol etc.
- We explicitly state that we are not responsible for faulty use of the equipment. The treatment equipment is for personal use of undersigned only! Other treatments and treatment of other(s) than the undersigned is strictly not allowed and therefore prohibited!
- By signing this form, you confirm receipt of a complete medicol® treatment set, including treatment colour tabs, directions for use, practice folder and a copy of this treatment contract/intake/anamnesis form.
- If you have got any complaints, we would higly appreciate you'r telling us thirst! Eventual mistakes, if any, can be corrected by us if possible. If you have got any questions we will serve you with pleasure. Please do not hesitate in contacting us!
- I herewith declare that i entirely agree - without any reservation - with all items mentioned above. Furthermore i declare that i truthfully filled out all demanded information w.r.t. this form.

Domicile: **……..**, **Date**: ….. - ….. - ……. Signature patiënt*: .....**

*****In case of minority or being under guardianship - both parents or legal guardian(s) have to sign this form (as well)!
**Above mentioned date = starting date of the treatment(s)

Name: ……..
Date of birth: ……

If necessary you can give additional information on this form.

Question 5:

Question 6:

Question 11:

Question 15:

Additional information to other question: