CTR-Test®
Chemotherapy-Resistance-Test

TherapySelect's copy

Therapy Select

Patient Data

First Name:

Last Name:

Street:

ZIP, City, Country:

Date of birth:

Telefon:

Email:

Treating Physician, Hospital, Practice

stamp

Patient Consent and Patient Order

Patient consent:
I have been informed by the above-mentioned treating physician about the nature, meaning, purpose and limits of chemotherapy resistance testing and I want to get tested. I am aware that live tumor cells must be removed.

Order and contract:
I authorize TherapySelect Dr. Frank Kischkel that a chemotherapy-resistance test (CTR-Test®) can be carried according to the requisition sheet. The terms and conditions listed overleaf, I acknowledge.

The total price for a CTR-Test® is: 1,995.00 EUR.

Optionally, other additional chemotherapeutic agents or combinations thereof can be measured. The total price will increase by 795.00 EUR, if up to seven more chemotherapeutic agents or combinations thereof are tested in addition. In case of tumor material which is inappropriate and no test result can be reported, there will be a failure charge of 500.00 EUR. The total price of samples from outside Germany might increase due to increased logistic costs. I am aware that I must bear the costs myself. Payment is by SEPA transaction.

Important notice for patients in hospital: The CTR-Test® is not provided as a general hospital performance of your hospital and therefore is not reimbursed through the hospital rate.

Additional consent (Please cross out, if you do not agree):
I hereby agree that the sent samples and data, including confidential findings on the subsequent clinical outcome, are used for research purposes. This serves to further improve cancer diagnostics and cancer therapy.

_____ _____

(Date and location) (Signature Patient)

SEPA Direct Debit Mandate

By signing this mandate form, you authorize (A) TherapySelect Dr. Frank Kischkel, Carl-Bosch-Straße 4, 69115 Heidelberg (creditor identifier: DE81001000010206 97) to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instructions from TherapySelect Dr. Frank Kischkel.
As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are explained in a statement that you can obtain from your bank. The mandate reference is (are) the invoice number(s).

_____

(Name of debtor(s), if debtor is not the above mentioned patient, please fill out in addition street name, number, postal code, city, country)

Account number IBAN: _____

SWIFT BIC: _____

_____ _____

(Date and location) (Signature of debtor(s))

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Account number IBAN: _____

SWIFT BIC: _____

_____ _____

(Date and location) (Signature of debtor(s))

CTR-Test®
Chemotherapy-Resistance-Test

Physician's copy

Therapy Select

Patient Data

First Name:

Last Name:

Street:

ZIP, City, Country:

Date of birth:

Telefon:

Email:

Treating Physician, Hospital, Practice

stamp

Patient Consent and Patient Order

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(Date and location)

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(Signature Patient)