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 credit card.

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.

_____ _____

(City, Date) (Signature Patient)

Credit Card Billing Authorization Form

Credit card holder authorizes TherapySelect Dr. Frank Kischkel to bill credit card once for the amount resulting from the number of drugs tested. Credit card holder agrees that all information provided is accurate and complete

Person Authorizing:

Credit Card Number:

Expiration Date:

Billing Address:

ZIP, City, Country:

Credit Card Type:

CVC Number:

(Last 3 digits from the back of card or 4 digits from the face of the card)

_____ _____

(City, Date) (Signature Credit Card Holder)

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_____ _____

(City, Date) (Signature Credit Card Holder)

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

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