PCDx™

TherapySelect's copy

Therapy Select

Patient Data

First Name:

Last Name:

Street:

ZIP, City, Country:

Date of birth:

Phone:

Email:

Treating Physician, Hospital, Practice

stamp

Patient Consent and Patient Order for Tumor Profiling by PCDx™ (Paradigm Cancer Diagnostic)

Patient consent:
I have been informed by the treating physician about the nature, meaning, purpose, risks and limitations of biomarker analysis of tumor cells and interpretation of the results. I am aware and understand that tumor tissue sampling is required from either an existing or a new biopsy or surgical sample when available. I agree to provide TherapySelect and its collaborators (in particular Paradigm) with such tumor sample and its associated medical information. I was informed that Paradigm is located in the USA and that the data protection laws might differ from the laws in my home country. I agree to process my data electronically only for the purpose of conducting the biomarker analysis and interpretation. I understand the potential risks involved with sending personal and medical information via email with regards to internet fraud. I agree to the use of my email address for delivering personal and medical information.

Order and contract:
I authorize TherapySelect Dr. Frank Kischkel that a biomarker analysis can be carried out according to the Laboratory Service Requisition form.
The price for the PCDx™ test is 3,995,- Euro. The prices for partial or other services can be requested separately. 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 above mentioned analysis is not provided as a general hospital performance of your hospital and therefore is not reimbursed through the hospital rate and must be paid by the patient.
By signing this form I declare that I have read and understood this form, including the general terms and conditions, as well as the Laboratory Service Requisition form previously signed by a physician.

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 services ordered. Credit card holder agrees that all information provided is accurate and complete

Person Authorizing:

Credit Card Type:

Credit Card Number:

CVC Number:

Expiration Date:

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

Billing Address:

ZIP, City, Country:

_____ _____

(City, Date) (Signature Credit Card Holder)

PCDx™

Patient's copy

Therapy Select

Patient Data

First Name:

Last Name:

Street:

ZIP, City, Country:

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Treating Physician, Hospital, Practice

stamp

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ZIP, City, Country:

_____ _____

(City, Date) (Signature Credit Card Holder)

PCDx™

Physician's copy

Therapy Select

Patient Data

First Name:

Last Name:

Street:

ZIP, City, Country:

Date of birth:

Phone:

Email:

Treating Physician, Hospital, Practice

stamp

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