TherapySelect's copy



(Date and location)



Patient Data First Name:	Treating Physician, Hospital, Practice
Last Name:	
Street:	stamp
ZIP, City, Country:	
Date of birth:	
Telefon:	
Email:	
for Tumor Pr	Patient Consent and Patient Order ofiling by PCDx™ (Paradigm Cancer Diagnostic)
analysis of tumor cells and interpretate required from either an existing or a note collaborators (in particular Paradigusthat Paradigm is located in the USA at agree to process my data electronical understand the potential risks involved from a large to the use of my email at a large and contract: authorize TherapySelect Dr. Frank Kontrology Service Requisition form. The price for the PCDx™ test is 3,995 of tumor material which is inappropriate above mentioned analysis is not reimbursed through the hospital rate and sy signing this form I declare that I havell as the Laboratory Service Requisitional consent (Please cross out, hereby agree that the sent samples and the collaboratory agree that the sent samples are collaboratory.	ave read and understood this form, including the general terms and conditions, as ition form previously signed by a physician.
City, Date)	(Signature Patient)
SEPA Direct Debit Mandate	
Heidelberg (creditor identifier: DE810 your bank to debit your account in acc As part of your rights, you are entitled your bank. A refund must be claimed	a authorize (A) TherapySelect Dr. Frank Kischkel, Carl-Bosch-Straße 4, 69115 00100001020697) to send instructions to your bank to debit your account and (B) cordance with the instructions from TherapySelect Dr. Frank Kischkel. It to a refund from your bank under the terms and conditions of your agreement with d within 8 weeks starting from the date on which your account was debited. Your that you can obtain from your bank. The mandate reference is (are) the invoice
Name of debtor(s), if debtor is not the above men	ntioned patient, please fill out in addition street name, number, postal code, city, country)
Account number IBAN:	
SWIFT BIC:	
Name of Bank:	

(Signature of debtor(s))

Patient's copy



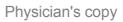
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fo	Patient Consent and Patient Order or Tumor Profiling by PCDx™ (Paradigm Cancer Diagnostic)
analysis of tumor cells a required from either an its collaborators (in part that Paradigm is located agree to process my da understand the potentia	the treating physician about the nature, meaning, purpose, risks and limitations of biomarker and interpretation of the results. I am aware and understand that tumor tissue sampling is existing or a new biopsy or surgical sample when available. I agree to provide TherapySelect and icular Paradigm) with such tumor sample and its associated medical information. I was informed d in the USA and that the data protection laws might differ from the laws in my home country. I ta electronically only for the purpose of conducting the biomarker analysis and interpretation. I I risks involved with sending personal and medical information via email with regards to internet to fmy email address for delivering personal and medical information.
Service Requisition form The price for the PCDx ¹ of tumor material which The above mentioned a reimbursed through the By signing this form I de well as the Laboratory S Additional consent (Plea	ct Dr. Frank Kischkel that a biomarker analysis can be carried out according to the Laboratory n. ™ test is 3,995,- Euro. The prices for partial or other services can be requested separately. In case is inappropriate and no test result can be reported, there will be a failure charge of 500.00 EUR. nalysis is not provided as a general hospital performance of your hospital and therefore is not hospital rate and must be paid by the patient. eclare that I have read and understood this form, including the general terms and conditions, as Service Requisition form previously signed by a physician. **Reservice** seems to further improve cancer diagnostics and cancer therapy.**
City, Date)	(Signature Patient)
SEPA Direct Debit	
Heidelberg (creditor ide your bank to debit your As part of your rights, y your bank. A refund mi	ate form, you authorize (A) TherapySelect Dr. Frank Kischkel, Carl-Bosch-Straße 4, 69115 entifier: DE8100100001020697) to send instructions to your bank to debit your account and (B) account in accordance with the instructions from TherapySelect Dr. Frank Kischkel. ou are entitled to a refund from your bank under the terms and conditions of your agreement with ust be claimed within 8 weeks starting from the date on which your account was debited. Your a statement that you can obtain from your bank. The mandate reference is (are) the invoice
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Version: 2020011615031

(Signature of debtor(s))





(City, Date)



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Email:	
1	Patient Consent and Patient Order or Tumor Profiling by PCDx™ (Paradigm Cancer Diagnostic)
analysis of tumor cells required from either a its collaborators (in path that Paradigm is locat agree to process my conderstand the potent fraud. I agree to the uniformatical authorize TherapySe Service Requisition for the price for the PCD of tumor material which the above mentioned reimbursed through the signing this form I well as the Laboratory Additional consent (PI hereby agree that the	by the treating physician about the nature, meaning, purpose, risks and limitations of biomarker and interpretation of the results. I am aware and understand that tumor tissue sampling is a existing or a new biopsy or surgical sample when available. I agree to provide TherapySelect and rticular Paradigm) with such tumor sample and its associated medical information. I was informed ed in the USA and that the data protection laws might differ from the laws in my home country. I attait electronically only for the purpose of conducting the biomarker analysis and interpretation. I all risks involved with sending personal and medical information via email with regards to internet set of my email address for delivering personal and medical information. The test is 3,995,- Euro. The prices for partial or other services can be requested separately. In case the is inappropriate and no test result can be reported, there will be a failure charge of 500.00 EUR. analysis is not provided as a general hospital performance of your hospital and therefore is not be hospital rate and must be paid by the patient. declare that I have read and understood this form, including the general terms and conditions, as Service Requisition form previously signed by a physician. The sent samples and data, including confidential findings on the subsequent clinical outcome, are sent samples and data, including confidential findings and cancer therapy.

(Signature Patient)