

## The Obligatory Regulations of RehaDent

1. RehaDent is located at Lanciego 19 lok 127, 02-792 Warsaw.
2. Payment methods and costs of visits are described in the price list tab on the website [www.rehadent.pl](http://www.rehadent.pl)
3. On the first visit, the patient should bring his/her medical documentation along with the tests imaging, if any (i.e. CD with X-ray, MRI, CT).
4. The patient receives a reminder with confirmation of the date of the visit 48 hours before the visit via SMS
5. **The patient is obliged to cancel the visit 24 hours before the scheduled date of the visit via SMS with information including his/her name, surname, date, and time of the visit sent to the phone number +48 531 389 992, or by phone call to the number +48 22 240 13 13 or in response to the SMS sent from the Medfile system.**
6. **In the case of your absence or the absence of information regarding the cancellation of the visit, it is considered completed and must be fully paid (100% of the amount). The payment term is 7 days from the date of the uncanceled visit. In the case of packets, the visit is deducted from the pool paid visits.**
7. **In the absence of information about the cancellation of the visit or cancellation less than 24 hours before, the patient is obliged to make a prepayment of 50% of the amount, no later than 3 days before the next visit.**
8. In the event of resignation from the purchased **personal** package, the payment return is reduced by the value tax + PLN 100 operating costs.
9. The patient is asked to arrive approximately 10 minutes before the scheduled time of the visit in order to leave their coat or use the toilet.
10. Invoices and bills as well as certificates to the Social Insurance Institution or private insurers are issued at the patient's request within 14 days from the date of the request.
11. By making an appointment, the patient accepts the aforementioned RehaDent regulations.

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*Date and legible signature*

## GDPR Informational Clause (Data Processing Agreement)

We kindly inform that:

1. The administrator of your personal data is RehaDent with its registered office in Warsaw at Lanci Street 19 lok. 127, hereinafter referred to as the Administrator; The administrator conducts the processing of your personal data;
2. The personal data inspector of the Administrator is Karolina Kotłowska, e-mail: [rodo@rehadent.pl](mailto:rodo@rehadent.pl),
3. The processing of your personal data will not be shared with other parties;
4. The processing of the Patient's personal data for health purposes pursuant to art. 9 sec. 2 letter h) of the GDPR, as a rule, takes place in connection with the performance of medical activities in accordance with the act on medical activities, while maintaining the obligations arising from the act on patient's rights and the patient ombudsman;
5. Providing data is necessary for registration, in the event of the failure to provide data, it is impossible to arrange a visit;
6. You have the right to:

- request from the Administrator to access their personal data, rectify them, delete or limit the processing of personal data,
  - bring up an objection to such processing,
  - data portability,
  - submit a complaint to the supervisory body,
  - withdraw consent to the processing of personal data;
7. Your personal data is not subject to automated decision-making, including profiling;
8. Your personal data will be stored by ArenaMed Rehabilitacja Medyczna for a period of 10 years in the case of lasting therapy (including consultation visits), and for 3 years after the end of treatment

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*Date and legible signature*

**PLEASE FILL IN WITH CLEAR PRINTED LETTERS!!!**

**Patient's Declaration (legal guardian)**

I hereby certify that the data provided above is true. I undertake the responsibility of reporting all changes of the medical situation/condition immediately following the occurrence, or as soon as possible.

PESEL number:

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I, .....

*(Name, Surname)*

resident of: .....

declare that **(I authorize / I do not authorize\*)** Mr. / Ms.

....., holding the legitimate personal identification

card numbered ....., to obtain information regarding my health

condition (the person under care\*) and - in the event of death - to obtain access to documented medical

information regarding my person (the person under my care \*), as well as copies, excerpts, and copies of

this documentation collected and stored at RehaDent.

I know my patient's rights under the Patient Rights Charter and I voluntarily consent to treatment within this clinic. The consent covers the performance of all treatments recommended and agreed to with the attending physiotherapist or other physiotherapists of the office

.....  
*Date*

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*Patient's signature (legal guardian)*