BUCHINGER
1920

REGISTRATION

PLEASE COMPLETE – IN ORDER TO GUARANTEE YOUR STAY

Salutation:	☐ Mr. ☐ Mrs. ☐ Ms.	Title:	
Name:*		First Name:*	
Date of Birth:*		Occupation:	
Address:*		Postal Code & City:*	
Country:*		Nationality:*	
Phone:*		Mobile:	
Fax:		e-mail:*	
Languages:*	☐ German ☐ English	☐ Others:	
Date of Arrival:*		Date of Departure:*	
Time of Arrival:			

TERMS OF PAYMENT

We kindly request a deposit of € 1,500 to be paid within one week of the receipt of your reservation confirmation. (Should the deposit not be received within two weeks of the delivery of your reservation confirmation, we will be obliged to charge your credit card with the sum of € 1,500.) Details of your credit card are obligatory as they guarantee your reservation.

☐ Please charge my credit card prior to my arrival

Credit card details:*	☐ VISA	☐ MasterCard	☐ American Express
Credit card holder:*		Credit card number:*	
Valid until:*		CVV (security code):*	

☐ Date of deposit: _____ via transfer to one of the following bank accounts:

Stadtsparkasse Bad Pyrmont
IBAN: DE59 2545 1345 0000 00 4242
BIC: NOLADE21PMT

Volksbank Hameln-Pyrmont eG
IBAN: DE08 2546 2160 0251 76 9800
BIC: GENODEF1HMP

PAYING AUTHORITY

☐ Private, requested accommodation: ☐ Blumenhaus ☐ Main Building ☐ Suite
☐ Other:

☐ State health insurance

IMPORTANT INFORMATION

Please note that the acceptance of a charge by state insurances can only be considered if received by the clinic before the registration is completed!

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Please be aware that our company has the right to receive full payment for your stay, plus any late charges, prior to your departure from the clinic. We accept valid credit and direct debit cards for all payments. Unfortunately we are not permitted to accept cheques. Thank you for your understanding.

☐ I confirm that the above information is accurate and correct. The credit card details above serve as guaranteed payment for all relevant costs incurred during my stay. In case my bill is incomplete at the time of my departure, I hereby authorize Klinik Dr. Otto Buchinger GmbH & Co. KG to charge my credit card with all outstanding costs due.

☐ I have read, acknowledge and accept the general business conditions, house rules and the current, valid price list for my stay. I confirm herewith my registration.

CONFIDENTIALITY AGREEMENT

☐ Yes, I agree to and am willing to allow my personal details to be used according to the data protection statement. My signature confirms that I have read the data protection statement of Klinik Dr. Otto Buchinger GmbH & Co. KG under www.buchinger.de/datenschutz, and that I acknowledge and accept the details of the statement.

Date, Signature	Date, Signature of credit card holder (if different from patient)

* Mandatory information

PRESENTATIONS & SOCIAL/CULTURAL ACTIVITIES

We organise presentations and social/cultural activities on a regular basis. Which of the following would you be especially interested in?

Lectures/presentations by doctors:

☐ Medicine ☐ Nutrition & health ☐ Spiritual & holistic medical aspects
☐ Ecology ☐ Art & culture ☐ Landscaping/Art of gardening ☐ Travel
☐ Others:

Various subjects:

☐ Chamber music ☐ Readings ☐ Theatre and museum visits
☐ Opera/symphony concerts ☐ Sightseeing ☐ Cinema
☐ Others:

Would you be interested in giving a speech or arranging an evening around a special interest, hobby or skill of yours which may also be of interest to other guests? We would gladly give you the opportunity to do this if is possible.

Proposed topic:

How was our clinic brought to your attention?

☐ Website: ☐ Publication:
☐ Friend (name): ☐ Doctor (name):
☐ Other:

Please return the completed and signed registration form by post, fax or e-mail.

THANK YOU!

Forstweg 39, 31812 Bad Pyrmont | Phone: +49 (0) 5281 166 0 | Fax: +49 (0) 5281 166 450 | e-mail: info@buchinger.de

WWW.BUCHINGER.DE

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MEDICAL REGISTRATION

Salutation: ☐ Mr. ☐ Mrs. ☐ Ms. Title: Date of Birth:

Name:* First Name:*

Date of arrival:* Date of departure:*

REASON FOR YOUR VISIT

Have you been a patient at our clinic before? ☐ no ☐ yes, from – to:

What is your own doctor's diagnosis?

What is the reason for your stay in our clinic? ☐ Prevention ☐ Therapy of:

HEALTH

In order to receive best possible results in your therapy, we need information concerning your medication.
All information given is subject to the medical code of confidentiality.

Medication (pharmaceutical ingredient): Dosage & time of intake:

Height (cm): Current weight (kg):

Do you suffer from allergies or intolerances?

Are you disabled or have any other physical infirmities?

☐ no ☐ yes, the following:

Are you capable of managing your daily routine by yourself without help? ☐ yes ☐ no

Would you like us to contact you with regard to planning your therapy? ☐ yes ☐ no

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ACTIVITIES, THERAPY & COUNSELLING SESSIONS

Are you interested in any of the following?

- ☐ Classes & exercises with the goal of calming down & relaxation
- ☐ Manual therapies & massages
- ☐ Physical therapy for pain relief
- ☐ Cosmetic treatments
- ☐ Minimal invasive aesthetic surgery
- ☐ Nutrition & health counselling
- ☐ Wellness treatments
- ☐ Physical mobilization/exercises – in groups
- ☐ Physical mobilization/exercises – with a personal trainer
- ☐ Physical mobilization/exercises – individual programmes

PLEASE NOTE

We are a non-smoking clinic – therefore we kindly ask you to leave the premises in order to smoke.

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Date, Signature

* Mandatory information

Thank you for your collaboration – we will do our best to consider your wishes.